The British Journal of General Practice

viewpoint

Revalidation: A Robust Procedure?

From the tragedies of the parents whose children are subjects of the Bristol inquiry and from the professionals whose careers have been ruined has come some good that should benefit all patients and the medical profession. The General Medical Council announced just over a year ago that revalidation will become a reality and is committed to approving a system for revalidation by June 2001.[1]

The RCGP established a Revalidation Working Group that has wide representation throughout the profession and one lay member. This Working Group has produced a document, *Revalidation for Clinical General Practice*,[2] now out to the profession for consultation. The Working Group recommends that revalidation should be a continuous process with an episodic submission of fitness to continue in general practice. GPs should collect evidence throughout the intervals between revalidation, thus avoiding an intensive period of data collection near the time of the submission and reducing the chances of problems with the revalidation process, details of which are still to be developed. The Working Group identified the following criteria to assess a system of revalidation. It should:

- be understood by the public and be credible;
- identify unacceptable performance;
- identify good performance;
- be supported by the profession and support the profession;
- be practical and feasible; and
- not put any particular group of doctors at an advantage or at a disadvantage.

So far so good! General practice should be congratulated for taking the initiative and for being the first of the medical specialities to produce such a document. But has the Working Group gone far enough? The system, let us remember, has to be both understood by, and credible to, the public. Individual patients and the public need to be reassured that the system of revalidation is sufficiently robust to identify unacceptable performance as described in *Good Medical Practice for General Practitioners*,[3] which elaborates the content of the GMC document *Good Medical Practice*.[4]

There is no doubt that, at the extreme of poorly performing doctors, patients, the public, and doctors will all agree about the obviously poorly performing doctor; for example, a GP who frequently demonstrates many of the items listed under the unacceptable GP in *Good Medical Practice for General Practitioners*. Where patients and the profession may not be in agreement concerns the performance of doctors who demonstrate some of the behaviour of an unacceptable GP some of the time.

The public discuss the merits of the doctors and know who is 'good' in the practice. 'Good' may be defined as getting to the bottom of the problem, being thorough, listening, examining when appropriate, and being able to explain things clearly. The opposite of all these patient definitions of 'good' fits the description of an unacceptable GP. If there is too much emphasis on peer review a now cynical public will not be reassured that such practice will be identified. So how are the public and individual patients to be reassured that GPs who demonstrate some of the behaviour of an unacceptable GP some of the time will be identified and advised appropriately?

Over the past year I have become increasingly aware and concerned about the disillusionment of some patients and members of the public with some GPs. It is not uncommon to hear such comments as "they don't listen", "they can't help", "they don't know me", and "they don't read the notes". Of course these statements are not part of a scientific study, but they do give a flavour of the concerns of some of the public. The question is will the system of revalidation be sufficiently robust to identify and correct such practice and therefore reassure the public? That balance for the profession and the RCGP is a fine one.

Patricia Wilkie

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The Back Pages...

'We seem dazzled rabbit-like by the statistics of significance wthout thinking what it means clinically and to the patient ...'

... John Holden uncoiling his coiffure, debating accessibility, page 168

'Situation Vacant ... "Lady Assistant … willing to assist in light household duties"'

... quoted by Jim Ford, reviewing Anne Digby's *The Evolution of British General Practice 1850-1948*, page 170

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news

holiday planner, 2000

6th Mediterranean Medical Congress and the 2nd Mediterranean Summer School, September 2000
Hosted by the Malta College of Family Doctors, the Summer School will be held between 5–7 September 2000 and the Congress will be held between 8–10 September 2000, both in the Westin Dragonara Hotel in St Julians, Malta.

Themes for the Congress will include topics in medical education (faculty development, teaching skills transfer, mentorship, distance learning, etc), clinical topics (Infectious diseases, chronic diseases, cardiovascular disease, haemoglobinopathies, child health, etc), and regional development and health care issues (health promotion, social change, isolated island populations, minority ethnic groups, etc). The Summer School will include updates in obstetrics and gynaecology, general practice, and advances in renal medicine.

A social programme is planned, and special rates for accommodation have been organised for delegates. The registration fee is US$175 for the Summer School, US$100 for the Congress, and US$225 for both.

Further information is available from MMS2000 Congress Secretariat at Howard's Travel, Holiday Inn Crowne Plaza, Sliema, Malta; tel (356) 342209; fax (356) 344547; e-mail **mms2000@synapse.net.mt**

Fourth World Rural Health Conference, August 2000
The University of Calgary will this be hosting this year's Congress in Calgary, Alberta in Canada. For further information please contact Irene Pullar at Continuing Medical Education in the University of Calgary, tel (403) 220 3379, e-mail **pullar@ucalgary.ca**

The Intercollegiate Group on Nutrition — Progress Report

The Intercollegiate Group on Nutrition (ICGN) was established in December 1996 with the primary aim of improving the competence in human nutrition of doctors and other health professionals. The Group now has formal representation from 11 medical Royal Colleges, together with nursing, dietetic, and pharmacist representatives. It issued its first report to the parent medical Royal Colleges in July 1997, where it recommended addressing two levels of competence through intercollegiate qualifications: a Certificate in Human Nutrition that would define a minimal level of core competence in the principles of nutrition, and a Diploma in Clinical Nutrition, that would ensure possession of competence relevant to an individual's clinical practice. Since that time, the Group has been working mainly on a course to achieve the first level of core competence.

A pilot course was held at the University of Southampton in September 1998, to bring together members of the ICGN and also some individuals who would wish to be future trainers, to help clarify content and methods of delivery. The course was also attended by an educational task force, supported by Rank Prize Funds which provide support in co-ordinating and standardising the delivery of the course. One of the key points from this meeting was unanimous agreement of the need for such a course to complement the present level of education in human nutrition. Specific aims of the course will be:

- to enable doctors to extend their knowledge of nutritional principles;
- to bring together sub-specialities to study nutrition in relation to disease processes and across boundaries of care; and
- to encourage the application of effective nutrition in relation to the promotion of health and in the treatment of disease.

The course design will balance nutritional concepts and supporting science with practical examples, real life experience, and cases relevant to all participants. Evidence-based human nutrition will provide one of several unified themes.

The course will take place over five days, and will be shortened on the first and last days to facilitate travel. The course will be residential, allowing time for informal interdisciplinary discussion and study.

The most likely participants will be trainees with an interest in nutrition, usually at SpR level. In addition, some consultants and GPs who are developing a special interest in nutrition are likely to attend. The course will also be open to other professional groups with an equivalent interest and background in nutrition.

The Group held two courses in 1999; one in Glasgow on 24–28 May, and the second in Southampton on 13–17 September, both well attended by trainees and consultants. The interactive nature of the course limits the number able to attend to about 25–30.

Extensive feedback was obtained from the participants and from the trainers at these two courses and this has been used to re-evaluate the course content and delivery, and modifications have been proposed for future courses. It is intended to hold a rolling programme of 3–4 courses each year, the basic structure and content of the course being similar at all sites throughout the UK. The number of courses will be determined partly by demand and partly by the availability of funding. A number of Postgraduate Deans have already recognised this course and Training Sub-committees are beginning to include it in training programmes. There are not, as yet, formal arrangements for an Intercollegiate qualification, but participants receive a Certificate of Attendance, and, where relevant, of CPD/CME.

Three courses will be held in 2000, and further details are as follows:

3–7 April
Southampton

Contact: Janice Taylor
Institute of Human Nutrition
University of Southampton
Southampton S016 6YD
Tel: 01703 796317
Fax: 01703 794945

22–26 May
Dunkeld

Contact: Caroline Fraser
Department of Human Nutrition
Yorkhill Hospitals
Glasgow G3 8SJ
Tel: 0141 2019264
Fax: 0141 2019275

18–22 September
Nottingham

Contact: Hazel Binks
School of Biomedical Sciences
Queen's Medical Centre
Nottingham NG7 2UH
Tel: 0115 970 9478
Fax: 0115 970 9259

Colin Waine
College Representative on the Intercollegiate Group on Nutrition

We need your opinion!

You should have received two important documents recently. *Good Medical Practice for General Practitioners* expands on the GMC's generic document and offers all GPs advice on what constitutes excellence and what is unacceptable practice. It is intended to inspire good practice and to offer a yardstick for us all to assess our care. These documents are extremely important because we intend that the criteria for an unacceptable GP will be used as the baseline for revalidation.

Revalidation for Clinical General Practice describes in outline how we currently see revalidation (the periodic confirmation of fitness to practise and thus continue on the GMC register) working in practice. There is still much detail to put into this framework but we need to be sure we have the framework right to begin with. Therefore we are inviting you to look at and comment on our thinking at this stage.

Revalidation is of vital importance for the future of our discipline. We must develop a method for reassuring the public that all doctors are competent, of identifying poor performance, and supporting underperforming doctors to help them get back up to acceptable standards. Ultimately, we must help those who cannot achieve the level of competence to leave our profession.

This is no mean task. And it will inevitably place more stress into our lives as well as increasing our workload. Your professional leaders would not be recommending it if we did not believe that it is an essential step to take.

We may not, of course, have got it right. You are the experts on this and we want to hear from as many of you as possible. If you think it can be done better, then please tell us. If you think we've got it right so far, then we need to hear.

This is no sham consultation exercise. The views of general practitioners and of patients will crucially shape these developments. So please respond!

Mike Pringle
RCGP Chairman of Council

Copies of both these documents together with response forms have been sent to every general practitioner in the UK. The full text of both documents and an e-mail response mechanism is also available for viewing or for download direct from the RCGP website (**www.rcgp.org.uk**)

The General Practitioner Writers Association

Writing is such a central part of a GP's job that many of us do not give it a second thought until we need to write up an audit or a piece of research. However, some doctors have discovered the incredible demand for articles written by GPs and have tapped into a market that, each month, publishes free GP magazines containing enough words to fill two copies of *War and Peace*. Other GPs write poetry or fiction, and sometimes join the bestsellers list.

The General Practitioner Writers Association (GPWA) is open to anyone who writes or aspires to write, whether it is factual or fiction. Its aim is to improve the standards of writing by GPs through providing educational and technical help. It also serves to act as a means of introduction between GPs, editors, and publishers. Above all, it provides a forum where GPs can meet and discuss all aspects of writing.

In one respect, the GPWA has the RCGP to thank for its very existence. It was at an examiners' conference in 1985 that, presumably in a gap between devising even more devilish exam questions, two widely published GP authors found themselves discussing writing. Soon they realised there was a need for a way for GP writers to meet and discuss their craft. A year later, the GPWA was holding its first meetings.

The association now has nearly 300 members from throughout the UK, Europe, and even the USA. Between them the range of interests, both medical and non-medical, is remarkable, and among its members are many of the profession's top writers.

The association publishes a register of its members annually. This lists members' biographies and interests. The register is sent free to members, selected editors, and publishers. Details are also published on the association website. This had led to many members receiving commissions for work. The GPWA also has a twice-yearly journal, *The GP Writer*, which publishes original work from its members and acts as a further advertisement for their talents. In addition, it publishes occasional books and a guide to writing which is free to members.

For many members, the highlight of the association is its meetings. The association holds Spring and Autumn conferences each year. Past themes for these include 'The Writer, Publisher and Editor', 'Medical Humour', 'Medicine, Music and Creativity', and even 'Medicine, Murder and the Media'! This May, the meeting is at Pitlochry and is on the subject of 'Communicating with the Community'.

The real pleasure of these meetings comes with their social side. Discussion, exchange of ideas, and the odd sing-song around the piano often go on late into the night.

The best news is that, even though it was founded by RCGP examiners, there is no membership exam. Simply contact the association at the address below and membership details will be sent to you. The website also has further details.

Whether you are aiming for the Booker Prize, or just wish to put some pizzazz into your medico-legal reports, the GPWA is the place for you.

Julian Spinks

The GPWA can be contacted at 633 Liverpool Road, Southport, PR8 3NG; tel/fax. 01704 577 839; e-mail: GPWA@lepress.demon.co.uk.
URL: **http://www.lepress.demon.co.uk/Home.html**

Mistake!

In the December issue of the *Journal* we attributed authorship of 'An MEQ for Christmas' (*Br J Gen Pract* 1999; 49: **1019) to Dr Andrew Hicks.**

Dr Andrew Hicks had submitted the piece for publication, but had not claimed authorship. It was in fact originally written by Roger Neighbour, at the time Convenor of the MEQ Paper of the MRCGP examination, and circulated privately among the Panel Examiners, under the title 'Not the MEQ'. We apologise both to Dr Neighbour and to Dr Hicks for our error.

Change and the individual 2: Psychoanalytic theory

The term 'psychoanalysis' often conjures up images of middle-class women recounting bizarre sexual fantasies in an old-fashioned, paternalistic, and somewhat obscure clinical context. What has all that to do with effecting change in the modern NHS — where interventions are supposed to be reproducible, evidence-based, and delivered by multidisciplinary teams in a community setting?

Psychoanalysis (Box 1) was a practice before it was a theory. Freud's clinical experiences in managing hysterical paralysis and other clinical problems led him to develop a theoretical framework for analysing the behaviour of individuals[1], groups[2], and society[3] which included the following key concepts:

- *The unconscious* — Emotional forces which lie beneath the conscious, knowing self have a powerful influence on both feelings and behaviour.
- *Free association* — the unconscious can be accessed via a technique in which the patient relaxes and reports whatever ideas come up spontaneously.
- *Symbolism in dreams* — the symbolic, manifest content of a dream provides clues to its latent content of uncomfortable or frightening unconscious impulses[1]
- *Repression* — painful impulses are forced aside before we become aware of their existence
- *Neurosis* — repressed impulses are expressed as maladaptive behaviour which the individual is unable to control or explain
- *Transference* — in all emotionally charged situations we treat people in ways that are coloured by early emotional experience.

Freud postulated that human motivation can be explained in terms of the unconscious conflict between the pleasure principle of immediate gratification (the libido drive) and the reality principle which demands adjustment to an external world (the ego drive). We do things either to gain pleasure or to survive. Whether the darker side of the unconscious is chiefly concerned with the gratification of genital sex (as Freud believed), the oral gratification of the breast (Melanie Klein), social success and influence (Adler), life energy in general (Jung), or language and symbolic power (Lacan), it is clear that something beyond reason and rationality determines much of human behaviour. Some examples of these are considered below.

Transference

The way we view men and women, bosses and juniors, and the organisation as a whole, will be affected by the unconscious impact of our early experiences. Thus, for example, having had a distant, authoritarian father may overlay one's present experience of, and emotions towards, a male authoritarian boss.

Conservatism

Structures and relationships that we understand and can predict have meaning for us. Altering these structures and relationships destroys our sense of both individual identity and collective culture. As Marris states, 'The impulse to defend the predictability of life is a fundamental and universal principle of human psychology'.[4] Individuals who resist change are often publicly decried as ignorant, recalcitrant, or obstinately protecting untenable privilege, in the incorrect assumption that their resistance can be broken down by exposing its irrationality.

Attachment

By attachment, Bowlby meant the young child's strong emotional bond with its mother (or, perhaps, the primary caregiver), from which springs comfort, joy, security, and the confidence to explore.[5] Strong attachments to 'nurturing figures' are frequently found in later life and may produce both constructive and destructive forces in the workplace. The emerging research literature on using opinion leaders to promote evidence-based practice is an example of an attempt to exploit doctors' unconscious attachment to 'figurehead' individuals in their professional group.[6]

Loss

Klein in particular has emphasised the profound emotional distress involved in the loss of a loved object.[7] Organisational change is inevitably accompanied by losses, which include:[8]

- physical comforts (e.g. a favourite desk, a place near the window),
- time with family,
- familiar territory, people and networks,
- ownership of a particular task or process,
- structure and clarity,
- power and influence.

Grief

The natural human reaction to loss is grief, which follows a predictable sequence from shock, numbness, denial, anger, guilt, panic, depression, to (hopefully) resignation, acceptance, and adaptation to the new situation. This entire spectrum was well illustrated recently by the reactions of many primary care professionals, and the subsequent service response, to the White Paper *The New NHS*,[9] which set out the strategy for the abolition of fundholding and establishment of Primary Care Groups. Individuals, and even whole organisations, can get 'stuck' in one stage of the grieving process, remaining (for example) in denial, anger, or panic. Alternatively, feelings may be repressed altogether, or displaced into resistance and resentment. [8]

Anxiety

From the organisation's point of view, individuals in the workplace exist in order to get the work done. But from the individual's point of view, the organisation exists as an external structure that gives comfort, predictability, and a set of rules ('norms') within which they can function securely. Obholzer suggests that all individuals at work have three anxieties:[10]

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Acknowledgement
I am grateful to Dr Jeremy Holmes for helpful comments on an earlier draft of this paper.

- primitive anxiety: the anxiety we all have from infancy of 'being left alone in the dark'
- anxiety arising from the nature of the work (for example, through transgression of cultural taboos such as privacy, nakedness, and sexuality)
- personal anxiety, resulting from past experience, both conscious and unconscious (most usually via transference).

Desire

According to Freud's pleasure principle, desire is one of the most basic human impulses, arising out of an unconscious feeling that there is a 'void' to be filled. It is probably a universal trait to want to be a 'top dog', loved by all, seen as brilliant, and so on. All this can be channelled into successful work in the right conditions. But if the conditions are wrong, pathology results — such as office affairs, arrogance, destructive competition, envy, and narcissism (see below). The psychoanalytic view of leadership holds that motivating staff is about aligning the unconscious desires of the staff with the stated aims of the organisation or its leaders.[11]

Envy and narcissism

Envy is another impulse that arises out of a sense of 'void', but instead of the creativity and energy associated with desire, envy produces feelings of anger and hatred towards the individual who is perceived to have the object that one lacks but cannot acquire. These feelings in turn lead to both narcissism (the illusion of perfection and omnipotence in which the envious individual attempts to take refuge) and guilt. Envy fosters regression rather than progression; it can be rapidly destructive in an organisational context (see case study).

Conclusion:
Managing unconscious impulses at work

Freud found that the physical symptoms of neurosis improved dramatically with 'talking therapy', and there is much to be said for the use of counselling methods in helping staff adapt to change. Strategies for dealing with loss, for example, should include acknowledging that the losses are real, giving permission and space for staff to mourn their passing, allocating adequate time and senior staff for empathic listening, and valuing rather than dismissing individual tragic stories.[8]

Bion uses the concept of 'containment' for the methods a skilled leader or manager may employ to reduce the potentially destructive impact of emotions in the workplace.[12]

Containment strategies include:[10]

- ensuring clarity of the primary task (individuals will be far less anxious if they have a precise and unambiguous definition of what they are required to do)
- attention to the boundaries between the organisation or work group and the 'external' world (for example, controlling the timing and content of information so that it is received when it can best be understood and acted upon)
- understanding symbolism and transference — in particular, addressing the scapegoating tendency whereby 'good' and 'bad' come to be located in different parts of the system (e.g. 'management' and 'staff', 'us' and 'them')
- detachment — i.e. careful and detailed observation of what is going on in a framework as free of preconception as possible.

In summary, people are no less emotional at work than they are at home. As change agents, we should:

- accept that 'it's okay to have feelings';
- recognise how powerful and potentially destructive the uncontained emotional agenda can be in the change process; and
- incorporate containment strategies into our agenda for change.

Trish Greenhalgh

Case study: Unconscious impulses on a PCG board

Dr Wendy Tripp is senior partner of a 'flagship' practice in north Bingwall, and chair of the Local Medical Committee. In 1999 she was unanimously elected chair of her Primary Care Group along with her long-serving and widely respected district nurse, Lorna Martin, and a bright and capable younger colleague from a neighbouring practice, Dr John Black.

Initially, the new PCG works extremely well. Dr Tripp's obvious competence, energy, and personal drive imbibe the PCG board with enthusiasm and the vision of a brighter future. "Our PCG", she claims, "will be the first to become a PCG Trust and will offer the best care across the board."

Six months into the new strategy, Dr Tripp has had angry encounters with several members of the PCG board. There is a general dissatisfaction with Dr Tripp's repeated invocation of 'chairman's action' outside board meetings. A list of suggestions from the nurses, presented by Mrs Martin, has been completely ignored. John Black's offer to present "strategies that are more evidence-based" for selected conditions is politely declined. Other board members feel they are being used as 'skivvies' to undertake tasks allocated by Dr Tripp, and deliberately fail to meet deadlines. As a result, she takes on more and more tasks herself.

Dr Tripp's evident desire to be 'the first and the best' appears to be overshadowing her ability to keep the team on board and respond to its complex, multiprofessional agenda. Her position as team leader (and her own view of herself as omnipotent) is initially reinforced as she takes on additional work and rejects offers of support, but she will soon lose credibility as it becomes evident that she is covertly stonewalling the efforts of popular and capable colleagues — of whom she may be unconsciously envious.[11]

Box 1: Two central principles in psychoanalytic theory

Contrary to popular belief, psychoanalytic theory is not fundamentally about sex. Its two central principles are that:[1]

a. The unconscious exists — i.e. human feelings, behaviour and symptoms are determined partly by influences inaccessible to our everyday awareness;
b. Early childhood experience has an important impact on the development of personality and subsequent behaviour.

Box 2: Psychoanalytic theory applied to the management of change: key points

1. The dominant models of change in most contemporary management theories (such as strategic decision-making and problem-solving approaches) emphasise the key competencies, skills, and knowledge for particular tasks or roles. Such models focus on the conscious, rational, and readily measurable aspects of human behaviour and are hence severely limited in scope.[13]
2. Managing change involves confusion, uncertainty, and paradox, as well as difficult emotions such as hate, fear, desire, envy, and anxiety. Successful change management requires an approach that acknowledges and works with the impact of emotions, both as an experience in management and as a driving force within organisations.
3. Anxiety, fear, defensiveness, avoidance, and anger often lie at the root of irrational resistance to change. These emotions may have many different origins, including the personal history of the individual, the nature of the task or change process, external factors, such as information flow, and the history and dynamic of a particular group or organisation.[10]
4. Emotion in the organisational setting (and especially in relation to change) may be experienced or repressed, managed or denied, kept in or passed on so that its effects are either mitigated or amplified in the organisation at large — a process that can be 'contained' by appropriate and

2

Postcards from a New Century

Generating clinically useful and usable evidence for primary care

*This article is the second in a series of 12 commissioned and edited by **Paul Hodgkin**, co-director, Centre for Innovation in Primary Care, Sheffield, and **Alec Logan**, Deputy Editor,* British Journal of General Practice*, London.*

The advent of any new idea is inevitably accompanied by the appearance of both iconoclasts and opportunists. The development of evidence-based medicine is no exception and has brought forth a number of articles highlighting the threat that such a philosophy represents to general practice. Some have indicated that it is too biomedical and ignores the broader perspective of primary care. Others have criticised it for a narrow focus concentrating on measurable phenomena and on randomised controlled trials.

I believe that the iconoclasts are wrong. As an opportunist I see evidence-based practice as a tool that empowers general practitioners. At last we have a chance to encourage the many non-clinical researchers who are colonising academic primary care to listen to primary care clinicians. The time is now ripe to shift the balance within the primary care research community towards research driven by the questions arising from day-to-day clinical practice. In the USA, Slawson and Shaughnessy have already introduced the concept of 'patient-oriented evidence that matters (POEMs)' to emphasise the practical importance of knowledge that focuses on something that is relevant to family practice and that has a direct bearing on the health of the patients encountered by family doctors.[1]

As a general practitioner, I need evidence that would help me to cope better with the thirty-sixth patient I see on a busy Monday who has multiple problems, multiple pathologies and is on more drugs than can fit on my computer screen. Within primary care we don't only see patients with the same problems as our specialist colleagues, we also see these problems at all stages from screening, through diagnosis and initial management, into continuing and, if necessary, palliative and terminal care. In addition we have to cope with our own unique problems such as acute cough, headache, night cramps, or otitis media. As highlighted in the MRC Topic Review on Primary Health Care, the evidence base for the management of most common conditions within primary care, both in the short-term and over a longer period, remains unsatisfactory.[2]

Many of the inclusion criteria within published randomised controlled trials are so exclusive that it often seems that the majority of the patients I see in my practice would fall at the first hurdle. Even if patients get into studies, the strict regimens and follow-up periods are inconsistent with the therapeutic heterogeneity and the long-term continuing care that takes place in general practice. There is real opportunity for general practitioners to indicate that, to be relevant, research ought to focus more clearly on effectiveness and not on efficacy. Trade-offs must be made between internal and external validity and research designs will need to be supported by funding bodies that more realistically address clinical issues in the real world of general practice. Pragmatic randomised controlled trials, patient-preference trials and, more recently, prospective cohort effectiveness trials may provide evidence on therapeutic effectiveness that is more generalisable to day-to-day general practice. Kemp and colleagues have recently successfully applied the latter approach in order to evaluate the use of zafirlukast in an unselected and heterogenous population of patients with asthma.[3] In addition it seems likely that n-of-1 trials, where patients serve as their own controls, will assume a growing role in appropriately tailoring treatments and therapeutic regimens to the needs of individual patients within general practice.[4]

The broad nature of primary care medicine is often ignored when research questions are formulated. According to Fletcher, clinical questions can be divided into a number of categories (Figure 1) and, as general practitioners, we need to assist the research community in defining more clearly what are the clinical questions that matter most to us in primary care in relation to specific conditions.[8]

Figure 1 (from Fletcher[5]):
Clinical Issues and Questions in the Practice of Medicine

Issue	Question
Normality/Abnormality	Is a person sick or well? What abnormalities are associated with having a disease?
Diagnosis	How accurate are diagnostic tests or strategies used to find a disease?
Frequency	How often does a disease occur?
Risk	What factors are associated with an increased likelihood of disease?
Prognosis	What are the consequences of having a disease?
Treatment	How does treatment change the future course of a disease?
Cause	What conditions result in disease? What is the pathogenetic mechanism of disease?

Many patients I encounter with asthma or epilepsy often seem more concerned about the prognosis than the management of their condition. As general practitioners we often worry about the consequences of tailing down or stopping treatments started by ourselves or by our specialist colleagues. Do the risks of long-term treatment with warfarin, omeprazole, anti-hypertensives, or diuretics eventually outweigh the initial benefits … and at what point or in what situations does a switch occur? With a few exceptions, such as Espeland's study of anti-hypertensive medication withdrawal, these fundamental questions appear to remain largely unanswered in primary care populations.[6]

Over 25 years ago, Howie described

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diagnosis as the Achilles' heel in general practice.[7] Even today it seems that medical research has yet to address in any meaningful manner what symptoms and signs indicate in primary care: just how useful is a particular symptom at predicting a certain disease, which symptoms are not useful, and which symptoms will rule out disease?[8] The current focus within the government's 'two-week wait' cancer policy initiative on the GP's ability to detect and refer cancers both promptly and appropriately serves to emphasise the differences in priorities in comparison with our clinical oncological colleagues in the cancer units/centres. In view of this, it is salutary to note that the evidence for the significance of chronic cough as a symptom of lung cancer or haematuria as a symptom of urological malignancy within primary care populations remains inadequate.[9]

The impact of disease prevalence in a population on the value of a test has led to fundamental misunderstandings between general practitioners and their specialist colleagues regarding the usefulness of many items of clinical information (i.e. symptoms, signs, or investigations), both for diagnosis and for screening. As can be seen from the 'symptom pyramid' (Figure 2), the proportion of patients with key symptoms in primary care who turn out to have an important condition, such as cancer, will be different from those seen within secondary care. To compound matters further the spectrum of patients encountered by our secondary care colleagues is distorted by a selective process of referral by ourselves as general practitioners.

The discriminant ability of any item or any cluster of clinical information in differentiating patients who may have a disorder from those who may not is expressed in a number of ways — most commonly sensitivity, specificity, likelihood ratio, or predictive value. All of these will differ in primary care partially in the case of the predictive value, not only because it is dependent on the prevalence of the target condition but also because patients frequently present to general practitioners with ill-defined problems and early/evolving symptoms. Time is a powerful diagnostic tool within general practice and, as it passes, and some patients are referred on up the pyramid, the increased definition of clinical information will alter the discriminant functions.

Within the UK over the last few years the development of primary care research networks has made primary care diagnostic research more feasible. However, significant amounts of time, funding, collaboration, and organisation will be required to complete the mammoth prospective cohort studies required. Academic departments will need to work together more closely with; perhaps, peripatetic clinical academic posts linked to large primary care research or commissioning groups. Furthermore, there is a requirement to sell the vision to the major funding bodies; for example, in relation to primary care diagnostic oncology, I am constantly lobbying the major cancer charities to persuade them to reconsider their funding priorities to incorporate diagnostic research.

As primary care medicine develops further and some of the key clinical questions are explored in greater detail it may also become evident that, for example, even the broad concept of diagnosis within unselected primary care populations is not synonymous with diagnosis within referred populations. Preliminary pilot work by myself in preparation for a larger study seeking to examine key primary care 'diagnostic pearls' has highlighted the use of a broader range of clinical information within general practice. It seems quite possible that quantifiable features of health seeking or health modifying behaviour, such as a patient's pattern of attendance, who accompanies them to the surgery, and recent changes in smoking status, may themselves have discriminant ability for cancer diagnosis within the community.

High quality primary care clinical evidence should be appropriate to our clinical needs. It should be equitable and acceptable in not discriminating against certain groups, such as the elderly but, on the other hand, recognising the practical realities and constraints of general practice. Evidence also needs to be effective in changing clinical practice but, above all, ways need to be found to ensure that the information published in peer-reviewed journals is accessible to the 33 000 general practitioners working throughout the UK. Slawson and Shaughnessey[1] have stated that:

$$\textit{Usefulness of clinical information} = \textit{Relevance} \times \frac{\textit{Validity}}{\textit{Work Factor}}$$

In addition to relevancy and correctness, the inclusion of the 'work factor' term emphasises that, if the information is published in relatively inaccessible places, general practitioners will simply not have the time or the inclination to search it out. In consideration of this, a USA-based editorial team is currently scanning 80 journals of interest to primary care clinicians to identify articles that have a direct and immediate impact on primary care practices. Recently, the information has become available via the Internet at http://www.infopoems.com

I don't work in simulated general practice with artificial patients; I work in real general practice with limited time and resources. I don't wish to read surveys whose primary purpose is to highlight my deficiencies or adequacies. As a generalist I am already fully aware of the limitations of my knowledge and skills in many areas. What I need is rapidly accessible answers to some of the key clinical questions that confront me on a daily basis as a general practitioner. Above all, I challenge the primary care research community to have the courage to stop conducting easy, short-term research on us and to start undertaking the difficult work on our primary care patients and their complex clinical problems.

Nick Summerton

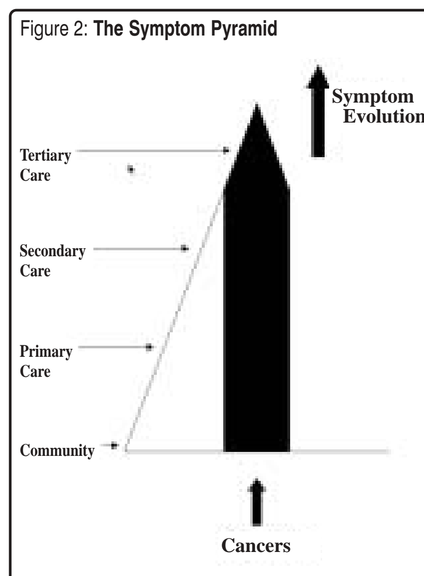
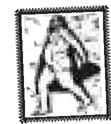


Figure 2: **The Symptom Pyramid**

The last book



Along with IT and genomics, there is a revolution raging in material sciences: new materials, with remarkable qualities. Coming soon for example is re-writable paper. Black and white charged particles are embedded in each sheet and when a charge is applied orientate themselves accordingly. The result looks like paper but can be used over and over again in printers and photocopiers. Good news for forests. But since the width of a piece of paper is thick enough to allow each individual 'pixel' to be wired, electronic paper heralds much more. Add some RAM to the spine of a paperback and you've got a book that can download 30,000 pages. All your practice's notes in a pocket-sized book updated each time you are on call. Or all the books you want to read on holiday just in a single paperback ...

Paul Hodgkin

conversazione ...

Are general practitioners accessible, valued and happy?

Mid-January, dark nights, and Spring seems a long way off.

Even peers of the realm forget themselves and stray off-message.

Virtual influenza grips the land and, in feverish surgeries, general practitioners, the New Concubines of publicly-funded health care, grow restive.

Dr O'Connell, feeling tetchy, sounds off on-line, and vigorous debate ensues ...

Comment welcome, to Journal@rcgp.org.uk

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Accessibility? Quality? Are they mutually exclusive in the current cash limited system?
To improve accessibility, i.e. to reduce the wait for a routine appointment to 24–48 hours we need to reduce list sizes. To reduce list sizes but still earn the 'reasonable' GP wage we need to be paid more per patient or perhaps per consultation. To improve quality, i.e. to spend more time with patients, examining them properly, and having that full and frank discussion fondly aspired to by MRCGP candidates (and the examiners), to spend time with staff and to manage our practices effectively — we need time. Time only comes with smaller list sizes.

Everyone wants clinical quality, accessibility, accountability, lots of continuous learning, job satisfaction, life quality, and so on. The quart won't go into the pint pot even though politicians, alert to electoral disquiet, wish it could. The media doesn't care what goes into the pint pot so long as their pages or airtime are filled — with anything sensationalist. Professional colleagues who ignore reality and honourably, but blindly, aid the regime and pronounce with mounting desperation that all will be right on the night are deluding themselves, and contributing to a debacle.

The system is fundamentally flawed. With more work falling into general practice as a result of a multitude of different influences only time will tell how long we have before the bottle cracks. Break up or shake up?

Recent rounds of bashing from the media, the politicians, and each night's abusive patients on the co-op (who have fantastic access) should not be tolerated. As I struggle to contain the expletives is it really only me who thinks they all need to be told to ... get real, pay up or shut up — as in all services, you get what you pay for — we cannot work any harder to improve both accessibility and quality at the same time, given the ludicrous contradictory pressure under which we operate. As they say in Yorkshire — "you never get ow't for now't".

I would like to propose 'shake up' rather than 'break up' and this means the profession putting the brakes on hard and perhaps starting to fight for general practice. I feel everyone is accepting that we are on the slippery slope — we are going down the pan and we're powerless to stop it.

Is this true? Are we getting any reward for our efforts? We're putting in GP managers to PCGs very cheaply. The quality money was pretty paltry, GPs pay isn't that fantastic ... and so on. Essentially, I'm concerned that we are collaborating with aiding our own demise and not standing up for ourselves or our patients.

I need to take some more Prozac now but please tell me your views.

Shaun

***Shaun**,*
I heard you in the heart! I have been obsessed all week with the difficulty that we have to get the 'quart into a pint pot' message out.

First, I had our PCG 'prescribing lead' nagging at us over a projected £750,000 prescribing overspend in our PCG this financial year. Redolent with threats and warnings, the message was 'either get your costs down, or face reduced resources for your practices'. No comment on the inadequacy of the fund available, or recognition that, as we grasp the quality nettle, our prescribing costs are likely to rise, not fall.

Second, I had problems from the hospital. We are victims of a 'slot system' in orthopaedics, that allows three new case referrals a month from our practice of 6300 patients. No matter that our caseload is heavily composed of new arrivals, with newly imported orthopaedic problems, yielding 5–6 bona fide referrals a month. What do I tell the fouth, fifth, and sixth putative orthopaedic referrant?

Probably the same as I told the mother of a young boy with an unsightly Meibomian cyst whose ophthalmic appointment is for April 2001! When she phoned the hospital to ask about the apparent misprint, she was told that they were now booking into 2002, and that, if he needed review of his priority, to go see the GP!

Sorry about the rant. This litany will be familiar to you all in different ways, I know. I just feel that no-one in the service really gives a damn and I wish I knew how to effectively highlight the fact that we are going under, and that the real people to suffer are those who are least able to articulate their protest. At what point does financial constraint lead to collapse? What does collapse look like? How can its causes be fairly identified and attributed?

How can I pretend to speak for quality in primary care, when some days I feel that I am hanging on to rationality by a thread (and sometimes, when the Irish temper takes command, not even that)?

Pass the Prozac, please.

Joe

Shaun and Joe,
Just to echo these sentiments, it is uncanny how similar they are to life in St Helens Lancashire. The deterioration in secondary care is now palpable, I have no confidence that anyone will get more than (at best) a barely adequate service. For many it will not even be that. For the first time in my 13 years of practice locally I definitely shudder at the prospect that some emergency would land me in our DGH.

We are also bust as a practice: we have overspent by about £87,000 at the last estimate. This is caused by more than 80% generic prescribing for years with no slack as a result, and the victims of the price stitch-up the Government has just ignored.

What will happen? The Government will ultimately be stuck between: (a) ever-increasing demands from the consumerism it has stoked, ever-increasing ability to keep sick people alive, and a demoralised profession, fed up with being told how hopeless we are and in desperate need of policing and therefore happy to work-to-rule, refer everyone with rectal bleeding, etc, and (b) the nasty question about who will pay. This can only be the general public of course, the only question will be whether it is through either overt or covert taxes, e.g. compulsory private health insurance with Medicaid for the poor and elderly.

What to do? I am sure we shall carry on with our heads down. I sense no mood to listen to the dark forces of conservatism, i.e. you and me. By all means we should keep one another's morale up where we can, but I see little point in trying to whittle down prescribing budgets and not refer people who need referral just to please managers.

I only wish our patients would write to their MP about their experiences, but they are not complaining people.

John

Shaun, Joe, and John,

Small additional resource can make a world of difference. My practice quality was on the slide until I got 2.5 sessions a week from a salaried doc to help with the drug addicts and alcoholics. We won't be able to hold onto this resource forever so save some of the Prozac.

But it isn't just resource. Socio-economic groups 1 and 2 use primary care more than groups 4 and 5. Are we designing a health service increasingly for the well?

We invent work for ourselves. My back-of-the-envelope calculation for prescribing folates is that I have a 50–50 chance of preventing a neural tube defect every 20 000 years. My reading of UKPDS 33 suggest that, by tweaking HbA1c more aggressively, I shall have no effect on mortality and in my professional lifetime shall save six microvascular complications, of which at least five will be unnoticed by the patient; that is, it will not result in handicap. The HOT hypertension study subtracting out the diabetics ***did not show*** *the need to treat hypertensives more aggressively. We seem dazzled rabbit-like by the statistics of significance wthout thinking what it means clinically and to the patient.*

Talking of patients ... they used to have colds which settled on the chest, then they had ´flu, this then transmogrified to chest infections and now I see the tip of the new pandemic of lung infections. There is no simple answer here. The wonderful Mollie McBride, when in central London, admits that she quickly found herself prescribiing antibiotics as a way of coping so I think this does show it is partly a resource issue. But I cannot help but wonder if we GPs have modified our apostolic function and cossetted when we should have challenged ... this boils down to consultation skills and personal lists ... it's difficult to educate someone you don't know and not worth the effort if you may never see them again.

In my part of the world secondary care is a tad more accessible than you have described though it is still poor. Many parts of the system are silted up with bad referrals (PCTs may sort this) and with secondary care holding onto patients unnecessarily. A £10 item of service payment for a letter liberating patients from secondary care would certainly be worth a trial in this neck of the woods.

Seasons greetings

Michael

John and Joe,

It is heartening to read your replies, to see that it is not just me and that others are as despondent. Like you, John, I would have grave concerns about me ending up in the local hospital. I have seen so many dangerous cock-ups where patients have not been harmed through luck and, occasionally, my vigilance that — although I don't have John's 13 years of experience, I can only assume — means the hospital is under ridiculous pressure too.

John wrote "I only wish our patients would write to their MP about their experiences, but they are not complaining people". My patients are, but in the main they complain to us. Without being party political I suggest they do write to their MP, stating that I have no power or influence to improve the systems that let them down (althought not infrequently I do write to the Chief Executive of the local Trust to inform him — the replies I usually get demonstrate an ignorant or deliberate avoidance of the issues by someone more junior).

I believe, though, that as a College we do have a little power and it's time to act, with the GPC, to cause a revolution (good sixth-form language). The public have to know, they have to decide whether this awful service can go on. It is not reasonable for us as public servants to be squeezed from both sides any more but do we have any self-respect left?

Shaun

A communication from the GMC has dropped through my letterbox today — Management in Health Care: the Role of Doctors. *It states (para 9): 'Doctors must take action if they believe patients are at risk of serious harm ...' and goes on (para 10): 'Doctors who receive [information leading to concerns about patient safety] have a duty to act on it.'*

Now I realise that this is specifically directed at doctors working in management capacities, but it does not seem to me to be such a far cry from our role as patients' advocates and so forth. Indeed, there is probably some other piece of GMC guidance tieing the two together.

Are not the concerns we have been raising specifically concerned with patient safety? Is there any difference in outcome for patients when a colleague is deficient and when they cannot access the secondary care services he or she is meant to provide through excessive waiting lists?

Clearly, my patients are 'at risk of serious harm' from six-month waiting lists for echocardiography and four- to five-month waiting lists for gastroscopy/ sigmoidoscopy ... and all the other enormous, and lengthening, waiting lists in south Lancashire.

The GMC instructs me (para 12) to make my concerns known first and foremost to more senior management (health authority chief executive/medical director?). If 'having taken all the appropriate actions described (in the booklet) doctors have good grounds to believe that patients continue to be at risk of serious harm, they may consider making their concerns public ...'

John

Such measured, understated wisdom!

The current contradictory statements coming from the politicians and others at Richmond House in relation to ICU beds and the ´flu epidemic, highlight the absurd unrealistic level of public debate that passes for serious comment re: our health system.

On the one hand we are stretched to the limit and there are concerns expressed about levels of demand, on the other hand demand is encouraged and we are told that all care that an individual needs will be provided. In spite of clear evidence to the contrary. The leader in *The Independent* on 10 January sums it up pretty well.

The College should provide clear evidence when making its official statements, which should also support clear and effective pressure from GPC.

Our essential allies are our patients; effective alliances with them should be developed not for our own interest but for theirs. On the whole as a profession we are largely ineffective at making common purpose to any effect with patients.

If we were able to, it would be very powerful, particularly in causing Government to respond. The current administration is, I believe, increasingly weak with regard to its health policy which provides opportunities.

Philip

digest

in brief

Karl Marx (Francis Wheen, Fourth Estate, London 1999, ISBN 1-85702-637-3) is an early candidate for biography of the year. Marx is fascinating, a colossus astride 19th century European history. He was of suitably colossal proportions, and, like Esau, the hairiest man of a very hairy century. Like Orson Welles in fact, and similarly a prodigy, entirely devoid of self-doubt.

Wheen's approach is, at times, memorably flippant; doubtless the reason why he earned a tetchy review in a recent issue of the *London Review of Books*. Serious scholars, after all, do not cite at some length Karl Marx's appearance on Monty Python (which, for those of you who missed it, involved Eric Idle asking Karl to identify the winner of the 1949 FA Cup to win a 'materialistic sofa') and, similarly, Wheen relishes for just a moment too long the fact that the famous Parisian revolutionary of the 1840s, Alphonse de Lamartine, suppressed his middle names of Marie Louis de Prat.

Such prudishness, however, ignores Wheen's achievement in rescuing Marx from the attentions of True Believers. Marx's influence upon a truly global culture was at least as profound as that of Darwin, Dickens, and Tolstoy, and he cannot always be blamed for the way in which central tenets of 'Marxism' were appropriated by unsavoury genocidal maniacs in subsequent centuries. Worth remembering when negotiations get tough over revalidation.

And, changing tack somewhat, one further recommendation ... **Quick Reference Atlas of Dermatology** (Ankrett and Williams, MSL, Turnbridge Wells, 1999, 0-9535982-0-9) is of practical usefulness in busy surgeries, with only rare mention of dialetical materialism.

Alec Logan

Health Policy in Britain
Christopher Ham
Macmillan, 1999
4th edition
HB, 237pp, £14.99, 0 33376407 2

The main target for this book is undergraduate students of social policy and administration — many future NHS managers, perhaps a few career politicians. For these, and for their teachers and examiners, it has obviously proved satisfying, having reached four editions.

For readers of this *Journal*, I'm not so sure. Chris Ham rightly builds his text around a historical narrative, concentrating not on what health workers do but how the are organised to do it. This diminishes its usefulness to GPs now involved in primary care groups, or their equivalent structures in Scotland and Wales, who might be most likely to consider reading it. Geoffrey Rivett's *From Cradle to Grave: fifty years of the NHS* (London: King's Fund 1998) provides an at least equally perceptive and interesting narrative, together with fascinating accounts of the developments in clinical care that provided much of the motive force for organisation change. I found Rivett's remarkably frank retrospective personal view of events as a senior civil servant more useful than the cautiously academic view presented by Ham.

Health policy is a strange subject. As taught by Chris Ham, Rudolf Klein, and other academic experts in social administration, it seems curiously unconcerned with the possibility that actual policies might be very substantially different than they are. They seem to assume that the main task for their students after they qualify will be to solve management problems within the narrow constraints of Treasury-controlled funding, Civil Service imagination, and converging market-led politicians mainly concerned with reducing the tax burdens on business. Tough at one point in his story, Ham concedes that the NHS became grossly underfunded in the 1980s, and has continued so ever since; the possibility that an increasingly wealthy society has other options is virtually ignored. If we take the idea of a primary care-led NHS seriously, this question will face every GP serving on a commissioning group, requiring imaginative answers, and enough courage to question official inevitabilities far more than Ham seems willing to contemplate.

Even traditional liberals manager better than this. The alternative offered by Ham is the particular view of two academic Marxists, Leslie Doyal (in 1979; I suspect she now thinks differently) in the UK, and Vincete Navarro in the USA. As Ham says, they explained both the very different health services in the UK and USA as particular examples of power and property relationships within capitalist economies, and their medical dominance as particular examples of exploiting class relationships. Few, if any, medical sociologists have ever claimed that even fully commercialised care systems can operate in the same way as ordinary commodity transactions between providers and consumers, so Ham can dismiss this view with little difficulty. It was always suspect, not least to other Marxists. A more interesting and important question is whether the NHS might already have central features outside the capitalist economy, not only as a necessary part of its social infrastructure but also its eventual successor as a basic economic model. That possibility has already been readily accessible in the literature since 1992. It has provided the main area of real contention for much longer. We all know the NHS has been increasingly commercialised ever since 1990, a tendency most of us have been concerned to resist. That means NHS economy and culture were once otherwise, and that production of health as a non-commodity value, and of patients as co-producers rather than consumers, are practical possibilities for the future. I hope that in his next edition, Ham will at least refer to this possibility.

Julian Tudor Hart

The Evolution of British General Practice 1850–1948
Anne Digby
Clarendon Press (OUP), June 1999
HB, 376pp, £48, 0 19820513 9)

Enthusiasts have long awaited this final part of the Oxford trilogy charting the evolution of present-day primary care. They will not be disappointed, for this volume fully equals its companions, and is also as diverse in its form and structure. The first volume,[1] by Loudon (himself a former GP), meticulously chronicled the emergence of our profession from early apothecary shops, the 1815 Act and the amalgamation of 'man-midwives', country, naval, and military surgeons to become general practitioners. The final volume[2] celebrated the 50th anniversary of the NHS with individual contributions from many of those responsible for the success of the generalist branch of medicine in our own time. Readers who want to trace our roots back even earlier should consult Burnby's delightful study.[3]

Professor Digby uses a novel approach to study the social history of the profession as it structured itself in ways that anticipated the gatekeeping referral system that has become an integral feature of both longitudinal patient care and demand management in the subsequent welfare state. She supplements the meagre professional records of busy doctors with an examination of *BMJ* obituaries, producing pen pictures of practitioners that reflect both contemporary culture and practice and review individual achievements through the eyes of close colleagues, students, neighbours, and mentees

As with the writers' previous work, carefully

chosen anecdote brings the work to life. The rise of women in medicine is charted in some detail; a notorious advertisement for a 'Lady Assistant … willing to assist in light household duties' illustrates how soon the profession got on with exploiting the economic advantages of female practitioners. Nor is the place of doctor's wives in 'family medicine' forgotten; a contribution here quantified shortly after the close of this period at £5 million per annum.

The rapid adoption of modern technology, especially the car, bicycle, and telephone are described, as also is the ingenuity with which the partners at a Wantage practice handled their local tax inspector. After a 'rich and bibulous meal' he was handed their accounts, allegedly making their high expenses acceptable to the Revenue.

Corner shop finances, dependence on a cocktail of poor law, 'club', and other appointments and later National Health Insurance practice, predominate throughout, although exactly what advantage (pecuniary or otherwise) one doctor acquired from being 'Captain of the Denbigh Fire Brigade' is not specified. The economic perils (and opportunities for writing) in 19th century practice, are illustrated by an as yet unknighted Arthur Conan Doyle waiting six days for his first patient in an under-doctored part of Southsea.

A surprising statistic is the rise in the proportion of GPs with MDs, peaking at about 65% in the middle years of the 19th century and subsequently declining dramatically. Whether these statistics included practitioners whom we would today call specialists is confused by the failure of the same graph to distinguish between specialist and undergraduate Royal College diplomas. This is hardly a blemish on a volume, which provides such an excellent chronology of the continuous growth in generalist medical practice before the NHS.

Jim Ford

1. Loudon I. *Medical Care and the General Practitioner 1750-1850*. Oxford: Clarendon Press, 1986.
2. Loudon I, Horder J, Webster C. *General Practice under the National Health Service 1948-1997*. Oxford: Oxford University Press, 1998.
3. Burnby JGL. *A study of the English Apothecary from 1660 to 1760*. London: Wellcome Institute for the History of Medicine, 1983.

The Land of Green Plums
Herta Müller
Granta Publications, July 1998
PB, 256pp, £9.99, 1 86207227 2

We know about dictatorships and totalitarian states; we have, almost, lived in them vicariously through books, broadcasts, and Hollywood. The arms race, the countdown to Doomsday, the casual talk of war as something that could, in the nuclear age, be won — all these trappings of the Cold War were our norm, the fabric of our lives for years. We read the memoirs of those who escaped, of those whose gods failed them; we read of those who could not escape, who were silenced by imprisonment or internal exile or death. We shivered in the presence of *1984* and *Animal Farm*. We watched Hollywood's comic opera version of the whole thing, with the industry writhing on McCarthy's rack while producing pictures whose stock vilains resembled those of the anti-Nazi pictures of a previous decade. Spy-stories — each more apocalyptic then the other — flooded the shelves, with fumbling explorations of a terrifying darkness that had, suddenly, become gold dust. The media had discovered the Cold War, trivialising it to a *Boy's Own* paper level of Kipling's Great Game, what with tales of of the threat of nuclear Armageddon, of the balance of terror being disturbed; of dreadful plans of world domination — and, of course, the thwarting of such plans at the last minute by heroic secret agents controlled by inscrutable spy-masters.

The Cold War is finished; old power blocks and alliances are broken, and the once-totalitarian states are struggling to survive in the new market economy. There are those, now able to speak, who tell it as it was — who seek , somehow, to empty themselves of years of isolation and terror and falsehoods and deprivation in a new generation of writing, devoid of mock heroics and polemics and daring adventures. Such is a remarkable novel, *The Land of Green Plums* by Herta Müller, set in the Romania of Ceaucescu's police state — itself a change from the usual preoccupation with Russia and East Germany. Here, in slow-moving, simple prose, is the anatomy of such a state. Here is what it meant to live in a such a society, where the informer ruled. To betray was to survive; communication was possible only by reading between the lines, and listening between the words. To attempt to leave, legally, was to lose employment and position; to attempt to leave by escaping was to risk death, a threat that followed even after such escapes.

The story-teller struggles to cope with living in such a society, as well as with the constant reminder of her father's war-time status as a member of the SS. She puts herself at risk by her membership of a small student group united by discontent and disenchantment, and hatred of the regime. They communicate in code, all too easily broken by the Secret Police. Friendship cannot withstand the pressures of such a society, and even their tightly cohesive group is torn by betrayal and suicide.

The book — as few others have done — conveys the drabness and the danger, the need to conform (and the self-loathing that comes with it), and sour smell and taste of fear that is everywhere. There is nothing for comfort, and the book's understatement heightens the horror of a society built on that same fear which corrodes its heart.

Michael Lasserson

Do We Still Need Doctors?
John Lantos
Routledge, New York and London 1997
PB 214pp, £10.99, 0 41592495 2

This is a highly readable book, and GPs in particular will recognise its many insights. Hospital consultants will be more resistant to it because it challenges many of the standard procedures and attitudes of hospital medicine. The most misleading thing about the book, however, is its title. It suggests that the theme will be that we don't need doctors because we can get our diagnoses and treatments from the Internet, or that we won't need doctors when geneticists have sorted us out pre-natally. On the contrary, the book strongly suggests that we do still need doctors — but they should see their patients in a broader and more humane context.

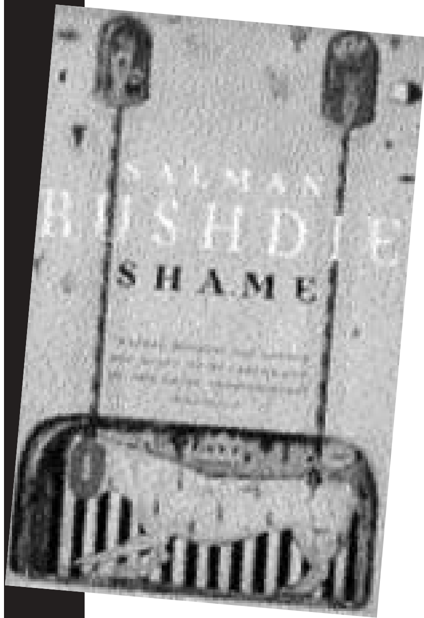
Athough the title of the book is misleading there is a strong hint about its style and content from something else on the title page This is a black disc which carries in white letters the sinister warning: 'As seen on OPRAH'. The book will certainly damage the health of those who are easily embarrassed, for it is highly personalised. As a quote from the top of the cover says: 'An excellent cry from the heart of an MD'. It is certainly not a cry from a stiff upper lip.

Nevertheless, most British doctors who are not put off by the cover will agree with much of it. It is just the style which is unfamiliar, for it is neither the style of a medical textbook (dryness) nor that of an ethics textbook (dryness). Yet it touches on technical medical problems — mainly in the author's own specialty of paediatrics, and on ethical problems and wider ones about medical education, the nature of modern medicine, and where it is going. The chapters are full of cases, although they are more vivid and personalised than the term 'cases' suggests, and the discussion of them is illuminating in ways which take us well beyond the details of the case. As another bit of the cover says, the discussion is 'insightful and challenging'. Problems of futile treatment, of the complexities of truth-telling, of dealing with relatives, and many others, are raised. The author has a broad background in philosophy, but doesn't do as so many medical philosophers do — pluck words like 'autonomy' or 'epistemology' out of the air. Rather, his philosophical knowledge is well assimilated and is used to provide a lightly sketched context for the book.

When I began reading it I found the book slightly cringe-making, but I got into this different way of writing and found the book moving and illuminating. I think that most readers of this *Journal* will have a similar experience.

Robin Downie

digest 2



Reflection:
Omar Khayyam Shakil and the Necessity of Doctors

'What's a doctor after all? — A legitimised voyeur, a stranger whom we permit to poke fingers and even hands into places where we would not permit most people to insert so much as a finger-tip, who gazes on what we take most trouble to hide; a sitter-at-bedsides, an outsider admitted to our most intimate moments (birthdeathetc.), anonymous, a minor character, yet also central, especially at the crisis ...'[1]

It is customary for a doctor to be called when there is trouble. But when an author faces difficulties we may be brought in as a character in their fiction; and our depiction may not be to our liking. This is a case report of how one of the most appalling doctors ever to have graced the pages of literature could be of service to one of the world's greatest living writers.

Salman Rushdie should need no introduction. Sadly, he is as well known for being in hiding as for his writing. Much of his early success, long before *The Satanic Verses*, was founded on *Midnight's Children* (1981), a novel detailing the fate of India following independence from British rule in 1947. It was not an altogether flattering portrait of the subcontinent, causing some resentment in India itself. How dare a writer who had left the country and spent most of his life in England comment on his homeland in this way? Some Western critics joined in, accusing Rushdie of 'the demythification of third-world nation-building, in a way that is sometimes held to confirm Western prejudices, showing that a new nation can act as abominably as the British did'.[2] Even the author himself admitted to 'guilt-tinted spectacles' when 'looking back at India'.[3]

In his next novel, Rushdie tackled this criticism head on. *Shame* (1983) details the politics of post-independence Pakistan in as inflammatory a manner as *Midnight's Children*. But the author speaks directly to the reader, declaring his right to comment from outside the country: 'Is history to be considered the property of the participants solely?' he asks.[4] Rushdie asserts that he had to write this story as Pakistan's own poets and writers had been repressed by successive regimes. His outsider's view of the country could not be perfect but was the only one available.

Rushdie underlines the grim necessity of his having to tell the tale by aligning himself with the 'hero' of the novel. This hero is a fat, philandering drunkard with no social graces or discernible morals. But he is 'essential'. Because Omar Khayyam Shakil is a doctor.

Named after the 12th century Persian poet, Omar Khayyam Shakil is an extraordinary creation. Rushdie cites his predecessor, of Ruba'iyat fame, as an example of the interplay between East and West. The parallels with Rushdie's own position could not be clearer:

'Omar Khayyam's position as a poet is curious. He was never very popular in his native Persia; and he exists in the West in a translation that is really a complete reworking of his verses, in many cases very different from the spirit (to say nothing of the content) of the original. I, too, am a translated man. I have been borne across. It is generally believed that something is always lost in translation; I cling to the notion — and use, in evidence, the success of Fitzgerald-Khayyam — that something can also be gained.'[5]

Omar Khayyam's bizarre upbringing, by three mothers, in the far West of the country marks him as an outsider. He is 'peripheral' and 'a creature of the edge',[6] much as Rushdie has described himself in his own critical writings.[7] He chooses to become a doctor under the influence of an Italian teacher, Eduardo Rodriges:

'"To Succeed in Life ... one must be Of the Essence. Yes, make yourself Essential, that's the ticket ... and who is most Indispensable? Why, the fellow who does the Dispensing! I mean of Advice, Diagnosis, Restricted Drugs. Be a Doctor; it is what I have Seen in You."'[8]

The choice of a Western career under Western influence further underlines Omar Khayyam's status as an outsider in his own country. Immediately after this passage Rushdie goes on to discuss why Omar Khayyam's 'peripheral nature' suits him to be a doctor:

'What Eduardo saw in Omar (in my opinion): the possibilities of his true, peripheral nature. What's a doctor after all? - A legitimised voyeur, a stranger whom we permit to poke fingers and even hands into places where we would not permit most people to insert so much as a finger-tip, who gazes on what we take most trouble to hide; a sitter-at-bedsides, an outsider admitted to our most intimate moments (birthdeathetc.), anonymous, a minor character, yet also central, especially at the crisis...'[9]

Rushdie, as the writer of this book, is 'a legitimised voyeur' gazing on what the Pakistani authorities have taken 'most trouble to hide.' Rushdie too is 'a minor character, yet also, paradoxically central', through writing this work of allegorical history about a country not wholly his own. Writers, like doctors, are an unpleasant necessity. The world needs to be satirised because it is so corrupt, just as doctors are needed because illness exists.

Omar Khayyam Shakil goes on to link all the central characters of the novel. They include thinly disguised portraits of Zulfikar Ali Bhutto and General Zia-al-Haq, both leaders of Pakistan and two of the most unpleasant dictators to trouble the world in the last 50 years.[10] But Omar Khayyam is one of the few characters in the novel to have been born and have live continuously in Pakistan. He would be 'allowed' to write the country's history by Rushdie's critics, especially with his access to the key figures shaping that history. But Omar Khayyam is almost totally without morality. One of his many crimes is falling in love with a mentally handicapped child under his care.[11] Not the ideal informant, but better than none at all. Omar Khayyam is a truly unpleasant necessity. But, like Rushdie, at least this 'legitimised voyeur' would be able to tell the tale.

Wayne Lewis

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8. Rushdie S. *Shame* London: Vintage/Ebury, 1983; p.49.
9. ibid.
10. ibid.; p. 141.
1.1 ibid.; p. 59.

Acknowledgement
Thanks to: Dr M G Williamson of The Open University.

More Country Doctoring ...

The December issue of the BJGP, containing Kafka's A Country Doctor, *arrived on my desk two days before Andrew Boddy, recently retired from the University of Glasgow, passed on to me an old set of papers he had come across on clearing out his desk. It included a signed copy of the first James Mackenzie lecture, given to him by William Pickles, first President of the College, when Andrew visited him as a young doctor in Aysgarth in 1961.*

Pickles is best known for his descriptive epidemiology of infectious disease in country practice, making good use of his knowledge of local social networks, more easily tracked in sparse country areas than in towns and cities, to explain the transmission of incubation and disease.

But Pickles's knowledge and records of his population had other uses. As he put it:

'These are just the people to help a doctor in his investigations. Matters so delicate as heredity and consanguinity have to be approached with care and tact, but I have found my own patients cooperative and slow to take offence. I have known the grandparents of many of my present-day patients and have been able to trace characteristics, medical and otherwise, through the generations to the present day.'

The article on the right, which appeared in the Lancet in 1943, provides a fascinating insight into the relationship between inheritance and environment in one Yorkshire farming family. The description stops at conjecture but illustrates another tenet from Pickles's first Mackenzie lecture: 'it is the role of the country doctor to collect facts from which others more skilled can draw conclusions'. Pickles would have been the last to call himself a genetic epidemiologist but he may have been the first to recognise the opportunities in general practice to study the epidemiology of disease in families.

Graham Watt

Reprinted from THE LANCET, *August* 21, 1943, *p.* 241.

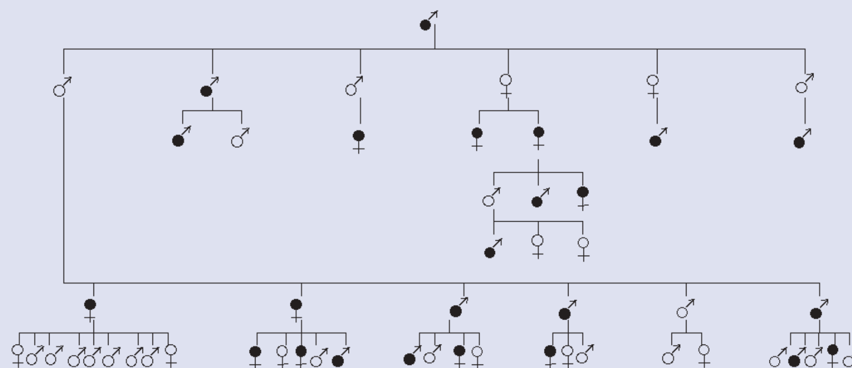
A RHEUMATIC FAMILY

W. N. PICKLES, M D LOND, M R C P

AFTER many years in country practice, my experience of rheumatic fever and rheumatic heart disease had been so meagre that I felt justified in considering them locally very rare. It then dawned on me that the sufferes mostly belonged to one large family and more than once the disease was discovered before the relationship. It was found possible to work out a family tree and to show that out of 53 descendants of a man — himself a victim — who died long before my time, 23 had suffered with rheumatic fever or had unmistakeable signs of mitral stenosis. Besides the original victim I had to accept hearsay evidence of but three others, having myself attended and examined the remaining 20. Of these, 10 have died; one from an accident in youth, the others from heart disease between the ages of 48 and 70. Four with rheumatic fever have come under my care — 2 only developing heart lesions. Nine with such lesions gave a history of rheumatic fever and 5 lesions were discovered without relevant history. One young woman developed mitral stenosis after tonsillitis and her sister after tonsillectomy.

The causation of rheumatic fever is rightly one of the most important objects of research at the present time, and as environmental influence is bound to loom large, it is as well to remember the existence of such families.

It is interesting and important to know what manner of people are being studied and something about their lives. After 30 years' close experience, I have no hesitation in singling these people out as among the most outstanding in the district. With insignificant exceptions they are prosperous, well-housed and well-fed. In personal experience they are much above the average, tall and broad with an unselfconscious dignified carriage. They have a proper and justified family pride and a sense of inheritance, claiming descent from a follower of Alan of Brittany upon whom the Conqueror bestowed Richmondshire. They are as a rule successful farmers but a switch-over to other occupations has simply meant adaptation of talents and success in a new sphere.



Black circles indicate members of the family with a history of rheumatic fever or signs of mitral stenosis

The victims of mitral stenosis do not seem to follow the usual rules for this disease. The men live the strenuous lives of hil farmers. The women, besides doing the heavy work of the farmer's wife, bear children and feed them at the breast, and all positively refuse to believe that any care is needed. Yet none of these sufferers has up to the present died from heart disease at an early age. The diagram shows the sufferers in black and spouses are omitted. In no instance was the spouse rheumatic, so that the story is uncomplicated.

It is futile to speculate on the destiny of this remarkable family. "It is not observed in history that families improve with time" may well prove true in a medical sense. It may be that environment has hitherto been so favourable for this family that it has helped its members in part to elude the shackles of inheritance.

I am indebted to Miss Marie Hartley, of Askrigg, for the diagram.

Reproduced with kind permission from the Lancet.

matters arising

Nomination of Fellows to serve on the Fellowship Committee 2000–2006

Three elected Fellows will shortly be retiring from the Fellowship Committee. Three new Fellows therefore need to be elected to serve on the Committee from 2000 to 2006.

Nominated Fellows should be willing to serve for six years. All Fellows are eligible for nomination except those who are currently members on Council or who have served on the Fellowship Committee within the past three years. The Fellowship Committee meets twice a year and prospective nominees should note that the first meeting will be on 11 May.

Nominations must be proposed and seconded and verified by the nominee. The nominee should also provide a supporting statement of not more than 50 words. All Fellows will be written to with a nomination form by mid-February. Forms must be returned no later than 31 March 2000.

Postal Ballot
Voting papers for the postal ballot will be sent to all Fellows during April 2000. A single transferable vote system will be used for the election. The successful candidates will be expected to attend the meeting of the Committee on 11 May 2000. The result will be declared at the June 1997 meeting of Council and subsequently published in the *British Journal of General Practice.*

Nomination for the Office of President of the College for 2000–2003

Professor Sir Denis Pereira Gray completes his term of office as President of the College at the conclusion of the Annual General Meeting on Friday 17 November 2000. Nominations are sought for the Office of President to serve for the three year period 2000–2003.

Nominations must be made by 12 Members of the College. Nomination forms and further details may be obtained by application to the Returning Officer, 14 Princes Gate, London SW7 1PU, Tel: 0171 581 3232, extension 246. Forms must be returned no later than 31 March 2000.

Postal Ballot
Voting papers for the postal ballot will be sent to all Fellows and Members during April 2000. A single transferable vote system will be used for the election. The result will be declared at the June 2000 Meeting of Council.

Missing References

In the December issue of the Back Pages in the *Journal* we unfortunately omitted to print the references and text citations accompanying the article ‘Measuring Outcomes in Primary Care: Time for an Injection of Common Sense’ by David Kernick (page 1026). We now print them below, and apologise to Dr Kernick for the omission.

The text citations were:

line 23
‘ ... research alone,[1] but the list is endless.’

line 31
‘ ... elements or dimensions.[2] You can ...’

line 33 and 34
‘ ... sense of coherence scale[3] to Ventegodt’s measure,[4] which encompasses elements ...’

line 59
‘For example, Stott[5] reflects this ...’

line 126
‘The celebrity adjusted life year (CALY)[6] ...’

lines 144 and 145
‘A recent paper in the *New England Journal of Medicine*[7] ...’

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**Good at writing?
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The editor of the RCGP *Members’ Reference Book* wishes to increase his database of knowledgeable, interested GP authors to write on clinical subjects for the RCGP *Members’ Reference Book*. If you are interested in writing for us and can write to a wordcount and brief, please send your name, contact details and a list of your areas of special interest to:

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neville goodman

Organising Oneself

I am pathologically organised; it is a terrible affliction. It's very impressive at work when someone comes to my desk and asks if I have any papers on some topic or other. I go to my computer reference manager program, search on a keyword, and up they pop. Of course, anyone can do this on MEDLINE, but it helps to have well-worn references passed on by someone who knows some that are worth reading. Having found the references, I go to my trusty boxes of 6×4 filecards and pick out the relevant cards (orange cards for research process, blue cards for philosophy of health care, pink cards for medical writing and statistics). An 'R' in the margin indicates a reprint or photocopy.

Which is all very well unless the filecard or the reprint is missing. When I'm writing an article, I collect the relevant filecards and reprints together in a folder and — this is the weak link in the chain — I fondly imagine that I will remember I've taken them from their proper homes. But I don't. Months later, with the article half-written or completed and forgotten, the filecard and reprint are missing. In fact, I have absolutely no idea at all where they are because they are not in their proper places. I am then incapable of doing anything except fretting about where they are. For days.

Eventually I print out another card and file it away, with the pathetic typed note: 'WHERE IS ORIGINAL???' As soon as I've done this the original turns up, sometimes because I suddenly remember a half-written article but more usually because I just happen across it misfiled in 'research fraud' (which is also on orange cards).

I have a colleague who is as disorganised as I am organised. His desk is a shambles of piles of papers, journals, and scraps of paper with things written on them. He never knows where anything is, but he knows "it's around here somewhere". Eventually it turns up, probably no sooner or later than I find my missing stuff, but — and this is what I think is so unfair— it doesn't worry him.

At home, all our recorded music is filed. If you want me to find a track by Spizzenergi, I can (it's on cassette tape 96, and on two compilation albums). But I've not cracked the books, and that really worries me. They're all such awkward shapes, and should art books be filed under artist or author? Answers on a filecard to…

Nev.W.Goodman@bris.ac.uk

james willis

Come up and see me some time

"I think I've done something silly", said Mrs Jones, vicar's widow, aged 87, "I've strained my hip climbing over a gate." Just before Christmas, this was, just before the new millennium.

I took the history. The day before, finding that an hour and a half of beagling was sufficient, as she does these days, she decided to take a shortcut back to her car. Only to find her route five barred and nobody about. "As I lifted my leg over the top I felt something go," she said. "'Oh dear,' I thought, 'now I've done something silly'."

The next lunchtime she caught me in the surgery when she rang to say that the tablets weren't working and she had had a bad night. "Do you think you could get here now?" I said, thinking the timing might work out nicely. "We'd better get that X-ray done straight away, you may have crushed a vertebra."

"Yes, alright, I thought it might be something like that."

I telephoned the community hospital and twisted a few arms; she could have the X-ray straight away, they were quiet, and the physiotherapy department discovered, when pressed, that Heather had a cancellation at four. So I had the two forms ready when she appeared at the reception hatch, her 'charity hat' with all its badges just visible over the sill. "That's very good of you, you make me feel very special."

"You *are* very special."

I was thinking of the day before in surgery, when she had suddenly pointed to my computer screen and announced that she was going to learn how computers worked.

"I was in the bank the other day and asked them how they worked," she said, "and they told me there was shop next door which sold them and they might be able to help me. So I went round. And do you know", she fixed me with her mischievous look, "they started to treat me like a fool. So I told them that I used to work with the first computer, Collossus, at Bletchley Park. Then they treated me differently."

The Wednesday before Christmas was my half day. On the way back from shopping I had an impulse to call in with my wife to see Cherry, one of my two centenarians who were going to make it so that they had lived in three centuries and two millennia, still living in her own home, albeit with a great deal of support. Surrounded by exquisite photographs of herself as a flapper in the twenties, as a Gaiety Girl, as a fashionable model. "Pretty little thing, wasn't I?". Ivor Novello, she once told me, was a much nicer man to have lunch with than Noel Coward. When I first knew her she was still driving herself to Spain in her Mini-estate and she had just been made a life member of the Bordon Camp Officer's Mess Badminton Club. She had 36 varieties of clematis in her garden and could name all of them. She still knows the names of all her carers. "They can't cook, they can't clean, they can't hurry, and they are all very NICE!" She wanted me to check her cholesterol when she was 96 and I said "Good heavens, what on earth would you do if it was up, change your diet?" "No," like a shot, "change my doctor!" Once, being wheeled out of the treatment room: "Come up and see me some time." And then shouting back over her shoulder across the crowded waiting room (unnecessarily): "That was Mae West!"

She was dabbing a blood-stained tissue on horribly painful, ulcerated lips (a new problem) when we arrived. So I left Lesley talking to her and walked the three hundred yards to the chemist and got her some Terra-cortril ointment, promising to send the prescription in the morning.

When I got back she had another visitor: none other than my Mrs Jones, hip pain duly improved. I had no idea they knew each other, but by an extraordinary coincidence she was the one other patient I particularly wanted my wife to meet this Christmas.

So there we are, that's my message, written over the New Year Weekend. In the last millennium it was people who were important and it was people who made general practice so rewarding. I expect it will be the same in the next.

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