The British Journal of General Practice

Viewpoint

Intellectual McCarthyism

It has all been so disappointing. I'm almost embarrassed to say it now, but on that day back in 1997 when I watched the live television pictures of Tony Blair arriving in Downing Street, I actually shed a few tears. These were tears of sheer relief, after all those painful years of Conservative rule. I had begun to feel ashamed to live in a country whose leader had said 'there is no such thing as society', where selfishness ruled, accountants counted, and where health care had been reduced to a market place.

But on that spring morning in 1997, it was at last possible that everything was going to change. People who cared were back in power. These were politicians who talked as if society mattered to them. They offered policies that promised to help those who needed most help, rather than policies that would make the rich richer, and blame the poor for their lowly place.

How naïve I was. It's rather embarrassing to admit it, as I have always prided myself on my realistic grasp on matters political, but these people really took me in. And one of the most disappointing aspects of the Labour government has been their extraordinary arrogance when it comes to dealing with the National Health Service.

Has there ever been a more despicable political argument than Tony Blair's accusation that anyone and everyone who disagrees with his ideas is a 'force of Conservatism' and can henceforth be ignored? This intellectual McCarthyism does Mr Blair and the Labour government no credit whatsoever. We have had to learn that our response to any Government initiative needs to be enthusiastically positive, as to offer any other opinion is clearly an admission that we are one of the 'forces of Conservatism', and therefore don't have opinions that are worth taking into account.

Indeed, if Tony Blair were now to give a speech in which he announced that, in future, two wrongs will make a right, anyone who points out that their experience indicates that this is not the case will simply be accused of being a force of Conservatism and will be cast aside.

It is all very sad, and it is all a dreadful mistake. Anyone who has really examined the work of GPs and the developments that we have introduced over the years will realise that in many practices development is a matter of constant evolution, experimentation, and evaluation. The astonishingly rapid development of the co-op system is hardly evidence of conservatism. The numerous practices offering extended opening hours, and an ever-increasing range of services, are hardly resistant to change. So why is our experience being ignored, and our enthusiasm being insulted?

The tragedy is that this arrogant attitude may yet destroy the very Health Service that it is supposed to be saving. Failure to recognize the incredible strengths of general practice, our remarkable cost-effectiveness, and the astonishing efficiency of the gatekeeper role, could ultimately bring the whole National Health Service tumbling down. General practitioners have an essential and highly skilled ability to tolerate high levels of clinical uncertainty without resorting to referral or over-investigation. Take away our role, or dilute our influence, and the flood gates will open and sweep waiting list initiatives and other fine intentions into complete oblivion. If we urge caution in changing the NHS, it is not because we don't care, but because we do.

And, of course, if you don't agree with me you must be wrong. Stands to reason, doesn't it?

David Haslam

The Back Pages...

'groupthink' — a shared sense of unanimity, invulnerability, and moral blindness, in which poor decisions are irrationally produced and fiercely defended ...
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'... the whole thesis of the evening was laid out before us: continuities, intimacy, surprise — the essence of general practice'
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Royal College of General Practitioners
SPRING SYMPOSIUM 2000
'A BREATH Of FRESH AIR'
14th-16th APRIL 2000
CRIEFF, SCOTLAND

In Scotland we are busy planning a weekend to end all weekends! Our aim is to bring together GPs and their guests from throughout the UK (and beyond!) to join in the first RCGP Spring Symposium of the new millennium, which is being hosted in the year 2000 by the College in Scotland.

For this special occasion, we have chosen a beautiful location — the impressive Crieff Hydro Hotel, which is situated on the edge of the stunning Perthshire hills. Not far from Edinburgh or Glasgow, the Hydro is renowned for offering some of the best accommodation and leisure activities in the region.

There are many exciting and important reasons why you should consider joining the Symposium meeting, such as to:

- learn and be challenged by our interesting educational programme;
- meet old and new colleagues from across the PHCT spectrum;
- be entertained by our exciting social events and activities;
- experience some of our famous 'Scottish' hospitality;
- make the most of Crieff Hydro's excellent sports and leisure facilities; and
- relax and enjoy some of Scotland's stunning scenery.

In addition to some potentially lively debates, highlights of the educational programme include interesting sessions on the topical theme of 'risk'; opportunities to focus on your own personal health and well-being; first hand accounts of the diversity of careers within general practice; and a briefing from Skoda on how we might improve our professional image! Sir Kenneth Calman will deliver the William Pickles Lecture on 'Aspects of Risk', and the Keynote Address and stimulating plenary sessions will be given by Drs David Colin-Thome, Phil Hanlon, and Phil Hammond respectively.

So, as you can see this is an event not to be missed, and we sincerely hope that you will not only come and support us as delegates, but also bring your guests, and encourage your colleagues to come along as well!

We really look forward to welcoming you to Scotland in April 2000 ... when you can expect to be treated to ... 'A Breath of Fresh Air'

For more details and an application form please contact the RCGP Spring Symposium 2000 Secretariat at 42 Silverknowes Road, Edinburgh EH4 5LF. Telephone: 44 (0) 131 312 7332, Fax: 44 (0) 131 312 7336. E-mail: events@charm.co.uk

Delivering the Public Agenda in the NHS
10 March 2000
The Commonwealth Institute
London

This is a one-day conference and exhibition aimed at strengthening the links between patient representatives and health care professionals at PCG and PCT level. The conference is hosted by the Doctor Patient Partnership and features seminars on understanding clinical governance, the role of lay members in PCGs, risk management, and the experiences of lay members on PCGs.

Further details and a booking application form are available from :
Sterling Events Ltd, 62 Hope Street, Liverpool L1 9BZ; tel: 0151 709 8979; fax: 0151 709 0384. E-mail: **DPP@sterlingevents.co.uk**; website: **www.sterlingevents.co.uk**. You can also visit the Doctor Patient Partnership website at **www.doctorpatient.org.uk**

Pharmacopoeia
3 March–15 April 2000
Contemporary Applied Arts
London

The first London exhibition of the work of Susie Freeman and Liz Lee, winners of the Sci~Art award from the Wellcome Trust, is an art and science collaboration that explores new ways of presenting important medical information.

The work considers the aesthetics of certain treatments, the quantity and variety of drugs that people take, and draws attention to effective mechanical alternatives.

In 'One for the Road', the long wait for NHS joint replacement operations is explored in a work consisting of a 10 metre floor installation containing 10 years' medication for a patient with osteoarthritis of the hip, an alternative treatment to the artificial hip joint.

'Come Dancing' (pictured), a dress containing 6300 contraceptive pills sewn into the fabric, represents the equivalent of 23 years'protection given by a single lippes loop coil.

Photography: Chloë Stewart

Sports Medicine...

The Sport and Exercise Working Group of the College have been busy with a number of projects recently. One of their most important roles is to support the College representative on the Intercollegiate Academic Board of the Medical Royal Colleges.

This body have taken preliminary steps towards recognising sports medicine as a specialty, have introduced a Diploma in Sport and Exercise Medicine, and are working towards developing specialist training. This Diploma in Sport and Exercise Medicine will be of particular interest to those general practitioners who are involved with various sports clubs and provide care to athletes. It is likely that, in the future, more sports organisations will join with the Scottish Rugby Football union, the Football Association and the British Olympic Association in suggesting that doctors involved with their sport, possess a higher qualification in sports medicine.

The Sport and Exercise Working Group of the RCGP would also like to draw members' attention to recent guidelines from the GMC for those doctors who may find themselves in a position of advising athletes

> *'Doctors who prescribe or collude in the provision of drugs or treatment with the intention of improperly enhancing an individual's performance in sport would be contravening the GMC's guidance, and such actions would usually raise a question of a doctor's continued registration. This does not preclude the provision of any care or treatment where the doctor's intention is to protect or improve the patient's health.*'

In a remarkable partnership between BMA Publishing and the RCGP there will be a unique Sports and Exercise Medicine Conference on 16 June at Chelsea Football Club. This collaboration is a result of meetings between representatives of the College Working Group, the BMA, and the *British Journal of Sports Medicine*. It will focus on the benefits and hazards of exercise and will have particular relevance for general practitioners who advise or prescribe exercise to patients in primary care.

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peter toon

Last autumn I was in Macedonia, helping with their health care reforms. Their post-communist primary care is burdened with a bureaucratic requirement to code for every consultation with an ICD10 diagnosis so that these can be collated centrally. Most doctors see no benefit in this and the data quality is poor. I rather smugly explained about our RCGP-led representative sample of enthusiastic, slightly obsessional doctors who took pride in producing good data.

Macedonian prescribing is riddled with perverse incentives. They often prescribe a more expensive drug because a cheaper, more appropriate one is not available. Sometimes, simple symptomatic remedies are not prescribed because the patient must pay for them, while more expensive unnecessary antibiotics can be given free.

Their Government recently introduced 'selected physicians' — everyone has a personal primary care doctor who acts as a gatekeeper to promote continuity of care. However, this is undermined because when patients present to other doctors, even with what are clearly non-urgent problems, those doctors feel obliged to see them.

This winter I worked in a London A&E department dealing with primary care problems and so helping to relieve 'winter pressures'. I am required to code a diagnosis for every consultation, using a classification I have never seen before. I just tick the boxes — whichever seems most appropriate. It's not worth wasting much time on it. I don't know what happens to these data — I presume that they are collated centrally.

Recently I had to prescribe co-amoxiclav because there was no penicillin in the drug cupboard. I am discouraged from writing prescriptions for symptomatic remedies not kept in the drug cupboard because the NHS cost of FP10s issued from hospitals is high (figures between £20 and £60 were bandied about by nurses — an awful lot for a bottle of nose drops) and then the patient has to pay a prescription charge. Of course if, instead, I prescribe an antibiotic it is free to the patient and the NHS cost is low.

Most of our patients have a GP, and the local co-op holds an emergency surgery around the corner in the evenings, but even when patients present with what are clearly not emergencies or urgent problems we have to see them. Yesterday I saw a patient who had had low back pain for five years — worse in the last two weeks, and another with an itchy rash who had seen his GP the day before.

Let he who is without sin cast the first stone?

Change and the team: group relations theory

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The Age of the Group?
The first two articles in this series were about change and the individual.[1,2] This article, however, argues that resistance to change often occurs at the level of the group. The ideas presented here were initially developed within London's Tavistock clinic for use with therapeutic (patient) groups and later extended to analyse the functioning (and malfunctioning) of groups and teams in organisations.[3,4]

Over the past 30 years, large organisations have tended to move from a predominantly vertical, hierarchical, and fixed management structure to a more horizontal and flexible structure based around semi-autonomous, project-based teams loosely co-ordinated from the centre. General practitioners have largely ceased to be isolated professionals and are now members of multidisciplinary teams who bring a range of knowledge and skills to bear on the complex problems of the population-at-risk and the individual-in-society. Students no longer spend hours on end in lecture theatres but enjoy (or endure) the challenge of problem-based, small group learning.[5]

The term 'group' has no universal agreed meaning, but two defining features are the social ties between its members and a sense of common perspective and purpose.[6] In the above examples the group's effectiveness is, at least in part, a function of the quality of social intercourse between its members. Groups in the workplace clearly have a very different function from, say, family groups, friendship groups, or therapy groups. Bion defined a work group as 'a planned endeavour to develop in a group the forces that lead to a smoothly running co-operative activity'.[3]

The 'buzz' of group relations
As anyone who has been a member of a Balint group, learning set, focus group, brainstorming group, Delphi group, project team, or indeed any other semi-formal group may testify, working in a group is often associated with powerful emotions, both positive and negative, which make the experience both fulfilling and exhausting.

Bion stated that 'the human individual is a political animal who cannot find fulfilment outside a group and cannot satisfy any emotional drive without expression of its social component'.[3] He argued that, for the individual, the task of establishing emotional contact with the group is a primitive and formidable act, involving both regression and loss of 'individual distinctiveness'. Indeed, Freud defined a group as 'an aggregation of individuals all in the same state of regression'![3] His theory was that large groups, such as armies or churches, become integrated social systems as each individual identifies (through transference) with the leader or figurehead.[7]

The psychoanalyst Lacan went further and argued that groups and masses locate in the group, itself the cause and object of their desire, and construct imaginary boundaries to strengthen the group's identity and protect it from perceived external threats.[8] A cohesive group with a strong work ethic may, therefore, work well in the short-term, but such a group is inherently resistant to change since any creative tension generated by individuals will induce a sense of group panic and be suppressed.[9] Pressure to conform within a group can be profound.[6] The dangerous phenomenon of 'groupthink' (a shared sense of unanimity, invulnerability, and moral blindness in which poor decisions are irrationally produced and fiercely defended[10]) may result.

Group relations as a mechanism for change
Box 1 summarises the broad principles of what is commonly referred to as group relations theory.[9] Figure 1a shows a widely used model for analysing the performance of an individual within a group, known as the Johari Window.[11] The first step in a group relations approach to the management of change is to help individuals identify their 'blind self' (behaviours and motives that are accessible to others but not to themselves) and confront their 'private self' (things consciously kept secret from the rest of the group). As Figure 1b shows, the former task is achieved mainly through feedback from other group members, whereas the latter is achieved mainly through self-disclosure.

In addition, feelings and impulses known neither to the self nor to others (the 'unknown' box in the bottom right corner of

		SELF	
		Known	*Not Known*
OTHERS	*Known*	Public self	Blind self
	Not known	Private self	Unknown

1a: Johari Window model of individual performance.

		FEEDBACK	
Self Disclosure		Public self	Blind self
		Private self	Unknown

1b: Johari Window showing effect of feedback and self disclosure.

Figure 1: Johari Windows

Figure 1a) may be gradually discovered through dialogue and reflection as the group builds trust and gains maturity (especially if assisted by an external facilitator). Much can be learned from asking what is being said, done, noticed, ignored, rewarded and taken on, by whom, at what levels, and in what roles (formal and informal) — and what is not being said, done, etc.[4]

The hypothetical case study (right) is based on an excellent chapter on the impact of group relations on the functioning of multidisciplinary teams in the health care setting.[12] It may initially appear that particular individuals are 'being difficult', but a deeper analysis shows that they are enacting a dynamic for which the group as a whole must take responsibility. Contrary to popular belief, successful group work in the workplace does not always require a high level of intimacy, but it does require an awareness that undeclared and unconscious impulses are likely to be influencing decision-making, and a level of disclosure and feedback appropriate to the task in hand.

Group relations and change in today's NHS

One year after another set of structural and contractual reforms were introduced into UK primary care,[13] many of us still feel little sense of common purpose and few affective ties with the other members of our local Primary Care Group. The pace of change has been such that we have not yet consolidated our new relationships, let alone built the trust necessary for honest feedback or self-disclosure. Perceived threats from 'out there' are many, but even 'in here' does not yet feel safe or comfortable. As a previous case study showed, the PCG leader's authority may or may not have been legitimised in the hearts of the members.[2]

Group relations theory offers no quick fix to these problems, but it does suggest some issues which PCGs (and other hastily assembled teams facing rapid change) should address as a matter of priority. First, they should gain agreement on each task and its boundaries, and define their individual roles unambiguously. Secondly, they should spend some time on the process of working as well as on the content of their agenda, however pushed for time they are. Thirdly, if the team is simply not pulling together then they should seriously consider involving an external facilitator to help them move to a more illuminated part of the Johari Window (Figure 1b).

Finally, the team should foster a working culture that supports, promotes, and rewards openness, constructive feedback, and self disclosure. The challenge of how to create or change a particular culture in a team or organisation is addressed in the next article in this series.

Trish Greenhalgh

Case study: A 'difficult' family on the practice list

Baker Road is a six-partner practice in an inner-city area with high levels of youth unemployment and petty crime. The practice buildings have recently been vandalised twice, and it is suspected that the three teenage sons of a 'difficult' family on the practice list, the Robinsons, are among the ringleaders.

The weekly practice meetings often feature a confrontation between Dr Geoff Jones (the most senior partner, who sees Mrs Robinson regularly for menorrhagia and depression) and Dr Bernie Laroche (the newly appointed junior partner). Geoff is in his mid-50s, staunchly conventional, and feels that children of this age need boundaries and discipline. He has pronounced the Robinson boys 'medically untreatable' and wants the crimes reported and the family removed from the practice list. Bernie is in his early 30s, wears jeans to work and reads *Socialist Worker*. He argues that teenage crime has sociopolitical origins, and that the practice should lobby the local council to improve facilities and create jobs. He wishes to drop one surgery a week to start a programme of 'outreach activities'. Geoff has suggested, ostensibly in jest, that Bernie is 'using all this political correctness nonsense as an excuse for going home early once a week'. The rest of the team often watch, amused or irritated, at the endless time-wasting between these two men.

An important aspect of this case is the behaviour of all the members in letting the arguments continue fruitlessly week after week, suggesting an investment on their part in maintaining the situation. Bernie and Geoff's altercations are, on an unconscious level, enacting the two sides of an unexpressed debate within this primary health care team about their role in society. Should they confine their activities to individual, 'reactive' and biomedical consultations, or should they begin to take a more community-based, 'proactive' and sociological approach – and if so, how?

Another issue is how the doctors use their power to keep a 'clean' practice list. By locating 'untreatability' in patients who have never registered with the practice, or with those who have behaved so badly that they have had to be removed, the team can unconsciously preserve their practice as a 'good' and safe place, while 'badness' and danger remain outside. The recent appointment of the left-wing Bernie Laroche probably represented a partial acknowledgement of this issue. But the team is now refusing to confront the full outreach agenda, which represents both a threat and an acknowledgement of the failure of their existing services.

If the team could recognise the deeper meaning of Bernie and Geoff's 'time-wasting' behaviour, they may then begin to address the underlying ideological controversy that concerns them all, rather than watch passively as it is played out before them.

Box 1: Principles of group relations theory[4]

- Individual behaviours at work are linked to group, organisational, and societal roles, and must be interpreted in context.
- The development and behaviour of a group depends not only on the relations between its members, but on the group's emotional, political, and structural ties (conscious and unconscious) to the wider organisation and society.
- An exploration of the emotional dynamics within and between individuals and groups, and the impact of the group's existing and emerging dynamics with the wider system (a concept known as 'relatedness'), is fundamental to both organisational learning and organisational change.
- Participants in groups learn in the here and now, by attending to, formulating, and interpreting emotional experiences both within the group and in relation to the wider system.
- Feedback and self-disclosure provide the opportunity for the individual and the group to get beneath the surface appearance of things.
- Reflection and feedback on feelings and emotions can enable individuals to stand back and explore their organisational meaning — i.e. to move from 'This is what I feel' to 'This is a feeling I have become aware of in myself'. In this way, the group can gain insight into the political, emotional, and relational forces that drive its behaviour.

Acknowledgement

I am grateful to Glyn Elwyn, Alec Logan, Fraser Macfarlane, and Clare Huffington for helpful comments on earlier drafts of this paper.

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Postcards from a New Century

Can dinosaurs learn to dance? — The future role of Community Ph

This article is the third 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.*

Just like GPs, the role of community pharmacists is changing quickly. So we asked Steve Morris and Bruce Warner to rattle the cages of both professions to see where we might be headed ...

'There is nothing about dispensing which needs a pharmacist these days, absolutely nothing. Community pharmacists are heading the way of dinosaurs.'

Dispensing Doctors' Association[1]

Historically, GPs have prescribed and pharmacists have dispensed. However, the role of community pharmacists — like that of GPs — is changing. Now that everything comes in patient packs why do we need highly qualified pharmacists to count out pills? In the USA, community dispensing is threatened by large drug houses taking electronic prescriptions and forwarding medication from a central facility. If the current service looks increasingly fossilised, what niche in the new ecology of primary care will the descendants of the dinosaurs occupy? And how will it fit with that other, possibly endangered species, the GP?

There are some 12 000 community pharmacies in the UK of which a large proportion are part of large chains. These are staffed by 21 000 community pharmacists, 47% of whom are women (often part-time). The total cost of this service is £755 million per annum for the UK.

Currently, most of the profession labours under poor pay and conditions. Proprietor pharmacists face ever decreasing remuneration, and community pharmacists employed by chains often have to cope with intolerable hours and conditions of work. Community pharmacists spend large amounts of their time trying to source difficult to obtain generic drugs, negotiating discounts for the NHS, and dealing with an untold amount of paperwork. Although 55% of Britain's 38 000 pharmacists work in the community, public demand for longer opening hours, the growth of supermarket pharmacies, an increasingly female workforce, and the change from a three- to a four-year degree have all led to a huge recruitment crisis and low morale.

Historically, dispensing has been the most significant of a community pharmacist's many roles; however, much of the work of dispensing can and should be done by technicians — as the *Pharmaceutical Journal* said in a recent editorial:[2] 'Supply is, of itself, no longer an adequate role for the 21st century pharmacist.'

While their supply function may be in decline, the advice role of pharmacists is likely to grow: NHS Direct and walk-in centres encourage patients to seek advice from their pharmacist and the range of products available without a prescription continues to increase. Finally, having pharmacists work directly in practices is proving highly effective.

So perhaps it is time to take a step back, look at what each profession is best equipped to do, and allow them to concentrate on that function.

Pharmacists know more about drug treatment than any other professional.[3] They train for five years, developing an understanding of all aspects of drug therapy, and many also undertake some form of postgraduate training in therapeutics. The (medical) chairman of the Medicines Commission has recently stated that: 'Pharmacists' expertise in the area of drugs is far greater than any of the existing prescribers. If anybody is to be allowed to extend into the prescribing arena then it should be highly trained clinical pharmacists'.[4]

Is it not time that doctors concentrated on diagnosing disease, and then pass on much of the management of prescribing for individual patients to the pharmacist? GPs could then focus on other aspects of the patient's care.

The recently published Crown report[5] allows for prescribing under strict protocol. In our view this does not go far enough. A suitably trained pharmacist should be allowed to prescribe in his or her own right, once a diagnosis has been made. Obviously the clinical and legal responsibilities of each health professional would have to be made clear. Spain has recently reviewed the competencies of both professions.[6] Can it really be long before similar steps are taken in this country?

So, how might this new service look? An increasing proportion of long-term medication would be devolved to central drug houses, as occurs in the USA. These would be supplemented by a small pharmacy outlet built into every new practice building, providing over-the-counter products, advice, and acute prescriptions. Pharmacist working here would truly be part of the primary care team and would be salaried by the PCG. Pharmacists employed in this way would be able to use their expertise in much more productive and useful ways: they could develop and implement formularies; patients with more than three significant co-morbidities would be automatically reviewed, as would anyone on more than six regular medications; complex patients who are diagnosed with a new condition would be referred to see the pharmacist and it would be the pharmacist who decided the best medication for them and issued the prescription; pharmacists would supervise local anticoagulation dosing and run a

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variety of treatment-based clinics, taking an holistic approach to polypharmacy. Joint pharmacist appointments between primary and secondary care would become commonplace as community pharmacists developed their clinical skills.

Such changes demand a major culture shift by both pharmacy and medical professions. General practitioners would have to accept relinquishing control of some prescribing to a third party. Such new arrangements would also require that patient registration with the practice conferred registration with the practice pharmacist, and that the pharmacist had access to the electronic record.

Community pharmacists would have to relinquish their control on all aspects of dispensing, but, with the advent of patient packs, better trained technicians and increasing use of information technology, the days of a pharmacist having direct involvement in every step of the dispensing process must surely be coming to an end.

How might these new posts be paid for? Some could be financed through more efficient prescribing,[7] but a more secure foundation would be a complete restructuring of the £755 million currently spent on community pharmacy services, with the emphasis for remuneration being taken away from the supply role. Another might be to develop the equivalent of PMS posts — pharmacists salaried by the PCT, still running commercial outlets for the benefit of the Trust, but mainly concentrating on their new role of primary care clinical pharmacist.

To do full justice to patients we need to move beyond simple co-operation within a mildly re-defined *status quo* and, for those brave enough, completely redefine the roles of each profession. Separating the roles of diagnosing and prescribing will mean that each profession will be in a better position to concentrate on what they do best.

GPs and pharmacists have a 300-year history of mutual co-evolution. The changing nature of both professions means that the time is ripe for another shift in how we view each other. Happily, neither profession is anything like the dinosaur quoted above and real opportunities exist to dramatically improve the quality of prescribing in primary care, create satisfying new roles that enhance the skills and effectiveness of community pharmacists, and preserve a reasonable number of small, community pharmacies. What is needed is the courage and freedom to adapt yesterday's practices to tomorrow's world.

Steve Morris
Bruce Warner

SNPs

Pharmaco-genomics — or why therapeutics is about to get more complicated

Why do some people respond to a drug much better than others? And why do some people develop fatal side effects while most of us can guzzle the same stuff with impunity? Part of the answer lies in the individuality of our genome. Differences of one or two nucleotides in the gene responsible for a particular receptor or enzyme may make no detectable difference to everyday functioning but may still be responsible for widely different reactions to drugs. Testing patients for such single nucleotide polymorphisms (SNPs) is just about to get economically feasible as combinatorial chemistry delivers 'laboratories on a chip' that can test for thousands of SNPs at a time. Each small chip has thousands of cells built up by the same photolithography techniques used to manufacture microchips. Each cell holds a different sequence of DNA; so to find the SNP you want, simply flood the chip with DNA and look for the cell that fluoresces the brightest. Currently, chips are still very expensive but there is a huge market and a proven technology, so watch out for Moore's law taking hold and prices halving every 18 months.

Initially, such testing will be limited to high risk situations but as costs fall it is likely to spread into everyday clinical practice. After all, no-one likes to be responsible for causing disastrous side effects and if you could test for an idiosyncratic susceptibility to, say, aplastic anaemia then you probably would. But its not just side effects — why prescribe an expensive statin to someone who is genetically predisposed to having a poor response? As the range of therapeutic products expands, so a decision may need to be made as to whether to screen recipients to see if they have SNPs that predict efficacy, or serious reactions. In short, choosing the right therapy is about to get a lot more complicated. Looks like pharmacists are joining the primary health care team in the nick of time.

Paul Hodgkin

E-mail consultations: Two years' experience from asthma information we

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The GPIAG Internet Service is supported by an educational grant from GlaxoWellcome.

Key Messages

- The Internet has become a major source of medical information.
- Many patients initiate an e-mail dialogue with health professionals, who in turn have an obligation to ensure that responses are accurate and helpful.
- E-mail consultations could become a standard part of modern medical care.
- 'Ground rules' are needed to protect patients and doctors.

Patients and health care professionals communicate in a variety of ways, including face-to-face contact, telephone calls, and letters. E-mail has become a standard communication medium in academia and commerce, and yet its use within health care has received little attention.[1] E-mail has advantages to patients in terms of speed, cost, and convenience. Health professionals appreciate the convenience of a medium free of time zone constraints, office hours restrictions, and with a facility to record precisely what was said, and by whom.[2,3] Fears about confidentiality, concerns about issuing inaccurate advice, worries that anything imported from America is associated with litigation, and unfamiliarity with a new medium have delayed the widespread usage of e-mail in United Kingdom general practice.

We took the opportunity to review a series of e-mail enquiries sent from patients to the Internet sites which we operate, i.e. British Lung Foundation, General Practitioners in Asthma Group (GPIAG), the Scottish Respiratory Site, and the University of Dundee Asthma Research Unit (ARU).[5] These sites were linked to a Question and Answer (Q&A) service aimed at health professionals and supported by an 'expert panel' consisting of GPs, a chest physician, a paediatrician, and a nurse. In the course of two years we received 274 e-mail enquiries which were from patients seeking advice about their own condition or that of a loved one.

Queries seeking simple basic information were replied to 'in-house' without recourse to the expert panel. Queries requiring detailed knowledge or which might be suitable for display (without personal details) on our websites were sent round the 'expert panel'. Panel responses were collated and sent back to each enquirer.

In the absence of published e-mail consultation guidelines, we operated the following professional code. The web pages' Q&A section clearly stated that we did not answer individual queries. Every reply made it clear we were giving a generic reply about asthma in general, not individual patients. All correspondence was directed through a central coordinator, not individual health professional e-mail addresses. The individual names of the panel were not assigned to specific replies although the composition of the panel was displayed on the Internet. Enquirers were always advised to seek medical advice, in keeping with standard practice in newspaper and magazine 'ask the doctor' columns.

Over a two-year period approximately 40 000 visits were made to the Internet sites. Users of the sites were from 21 different countries with around one half of all traffic originating in the USA. Enquirers were asked to state their professional background. Those who did so were predominantly from academic, marketing or student groups. The topics of questions were diverse, with more unusual ones asking for advice about building hypo-allergenic houses, the climate in Glasgow, the Buteyko method, and the link between heart disease and asthma. A total of 274 questions were received over two years.

Selected questions and panel answers

The most common topics enquired about were drug side effects and issues concerning steroid safety, atmospheric pollution, and symptom control. A selection is given in Box 1.

Patient feedback

Forty-one enquirers subsequently sent a further e-mail. 'Thanks for your prompt response' was a common reply. We have received postcards from various parts of the world with 'Thanks, I'll keep in touch'.

E-mail consultations are likely to become an integral part of patient health care professional communication.[6] Whether doctors like it or not, people with health care questions or problems will seek to contact them. If this contact is by e-mail then perhaps it constitutes a new form of consultation.[4] Our experiences suggest that there is patient demand for advice, support, and dialogue using e-mail as a medium. This demand may be met by those with a vested commercial interest. Patients could easily be misled by information displayed on the Internet which is out of date, inaccurate, or wrong.[7,8] We opted to meet demand for information about asthma by running a monitored Q&A service resourced by an expert panel free of commercial bias. This experience may be of interest to others.

Reports of 'e-mail consultations' from the USA suggest that both doctors and patients welcome the chance to extend their communication by exploring a new medium.[3,4] In many clinics it is standard practice to book consultations through e-mail. A pre-consultation e-mail questionnaire is available for some USA Asthma and Allergy Clinics. A natural extension of this is for a two-way patient–physician dialogue, particularly if the patient lives many miles from the clinic they are considering attending.

In the UK, e-mail is firmly established in academia, commerce, and education.[9,10] Many UK doctors, particularly those who work in universities and thus have readily accessible e-mail addresses, may have experience of e-mail consultations. It is hoped this article will encourage doctors to share experience of this new medium.

E-mail has many advantages as a consultation medium. It is quick, inexpensive, and unconstrained by time zones and office opening hours. Enquirers have the opportunity to carefully plan their questions. Responders can plan their replies, answer at any time of day, from office or home. Responses can be researched, information checked and if necessary linked using hypertext to an appropriate site. For example, some of our replies to UK enquiries contained the hypertext Internet address of the National Asthma Campaign. This facility leads the enquirer directly onto the Internet site which

best fits their need. Frequently asked questions (FAQs in Internet jargon) can be compiled and displayed on websites. Unlike a face-to-face consultation, an e-mail dialogue is saved word for word and can be printed out for future reference. This may be particularly useful when discussing a treatment plan for common illnesses subject to recommended guidelines, such as asthma. A curiosity of e-mail consultations is that doctor and patient need not meet. Experience from the USA suggest that patients accept this and can welcome the informality of an electronic dialogue.[3,4]

The main disadvantage of e-mail consultation is fear of the unknown. Patients can have concerns that the 'doctor' they are communicating with may or may not be qualified. Doctors have a fear that general advice, which they give about a disease, may be misconstrued as specific recommendations about an individuals' illness. Clearly, e-mail cannot and should not supplant face-to-face consultation and clinical examination.

At present, only a minority of UK citizens have access to e-mail and only a very small minority of doctors are accessible via e-mail. It would be unfortunate if doctors concentrated their energies on communicating with the technologically literate section of society and neglected those disadvantaged through lack of access to the Internet.[11]

The medicolegal aspects of e-mail consultations need to be addressed. A simple ban would be unworkable and simply turn patients towards unreputable Internet sources of information. Nonetheless, some form of guidance or set of 'ground rules' would be helpful. There are genuine worries concerning confidentiality of e-mail consultations. Financial transactions on the Internet can be protected by password systems. It is possible to apply similarly strict security systems to medical dialogue. The attraction of e-mail to some patients is its informality. If patients and doctors accept that e-mail consultations are not appropriate for diagnosis and treatment transactions but are a means of transmitting generic advice then confidentiality becomes less important.

Our findings are a speculative 'first step' in exploring e-mail consultations in the UK. Further work should address patients' and health care professionals' views on e-mail. Results from individual practices that were able to characterise a patient's medical condition, socio-economic background, and consultation pattern are needed. A way needs to be found to allow the elderly and socially excluded members of society equitable access to e-mail dialogue with health professions needs.

E-mail dialogue between patients and doctors is here to stay. The challenge is not to resist it, but to debate and research how to use this new medium to improve health care.

R Neville, F C Warner, C McCowan, G Hoskins

Box 1: Selected questions.

Question 1
'Recently, I have been taking prednisone for my asthma. I have now gotten off of the 40mg a day of prednisone. I have developed severe leg cramping: is this due to the steroid?'
Answer:
Prednisolone in high dosages, especially when used with beta agonists or bronchodilators, can reduce blood potassium levels, causing cramp. Fruit juice and bananas have lots of potassium!

Question 2
'My seven year old son and I are both sufferers. My question is about his current medication: he uses Intal twice a day with Ventolin for bad days, i.e. when he has a cold, etc. I am not convinced of its effectiveness, what would be best for him out of today's drugs? He has been hospitalized twice whilst taking Intal and gets wheeze about once a week and requires Ventolin. His average peak flow is 190.'
Answer:
Guidelines suggest patients not controlled on one step of treatment should 'step up' e.g. onto low dose inhaled steroids. A check on inhaler technique would also be standard practice.

Question 3
'How do you use a peak flow meter?'
Answer:
Peakflow is a measure of how fast you can blow air out of your lungs, therefore a measure of how wide the airways are at the time of the test.
How to use: Stand up; hold peak flow meter horizontally without restricting movement of the marker; ensure marker is at bottom of the scale; breathe in as deeply as possible, seal lips around mouthpiece and breathe out as quickly as possible (rather like blowing candles out at a cake); Record this result; repeat twice more. Choose the highest of the three readings and compare with your best or predicted value.

Question 4
'Do you have any information about the relationship between tree pollen and asthma? Basically do tree pollens cause asthma attacks? Is there any relationship between asthma and urban air pollution?'
Answer:
Asthmatic patients can be sensitive to a number of trigger factors. Pollen from any source and spores from trees in the autumn are just some triggers but not every asthmatic is sensitive to the same triggers. Air pollution can be a trigger for someone already asthmatic. Does it cause asthma? — the jury is still out.

Question 5
'My girlfriend using the most powerful neb. Can I get a power lead that plugs into my cigar lighter in the car or do I need to purchase a "travel" neb for her?'
Answer:
We suggest you contact the NAC which is a charity-based organisation offering support for asthma patients and their relatives, they are very friendly and will be able to help you with your query and put you in touch with their representatives in your area. Their helpline is 0345 010203 or you can visit them at their new web site http://www.asthma.org.uk.

Question 6
'How would you recommend a person with asthma control the condition better when the person suffers many unpredictable troughs on a daily basis?'
Answer:
We would recommend that the person concerned visit their GP and explain all the symptoms being experienced. It would appear that their SMP needs a reappraisal.

Question 7
'Can you please tell me the difference between steroids and antibiotics, having been prescribed steroids to treat a severe case of asthma, I would like to know the difference between the two.'
Answer:
Steroids reduce inflammation in the chest by "switching off" or "dampening down" parts of the immune system. Antibiotics kill bacteria but have no affect on asthma.

Question 8
'I am trying to collect data regarding if and how moving from where sufferers live to somewhere else has proved beneficial to asthmatics.'
Answer:
Difficult to prove scientifically that moving helps or not because one cannot do a randomized controlled trial on the subject. Lots of good studies on migrating populations. Start with Ian Greg's Chapter in Asthma (*Chapman and Hall 1983, Ed: Tim Clark).*

Acknowledgements
Thanks to all the unpaid volunteers in the expert panel who helped answer queries, including: Drs Dermot Ryan, Hilary Pinnock, Kevin Gruffydd Jones, Mark Levy, David Price, Bharat Karbal, Paul Stephenson, Somnath Mukhopadhyay, John Winter, David Bellamy, and Vincent McGovern.

Practising Evidence Based Geriatrics
Sharon E Strauss and David L Sackett
Radcliffe Medical Press, 1999
PB, 160pp, £30, 1 85775394 1

Practising Evidence Based Mental Health
John Geddes, Stuart Tomlin, Jonathan Price. Edited by Sharon E Strauss
Radcliffe Medical Press, 1999
PB, 232pp, £30, 1 85775415 8

When I was 10 or 11, I saw a model Lancaster displayed in a shop, beautifully painted, the camouflage correct, the bars in the cockpit canopy precisely drawn, no smudges, everything perfect. My father bought me the kit, but I smeared glue everywhere, couldn't paint a straight line, couldn't spread the colour evenly and ruined the transfers. But I kept on making models, developed my skills, and when I was a GP trainee (I confess it!) built a Lancaster even better than the one in the shop (of course it got broken, like all the others).

These books are 'EBM kits', derived from the format used in the UK workshops on teaching EBM. Each contains reprints of articles on EBM, extracts from the book *Evidence-based medicine: how to practice and teach EBM*, appendices with a glossary and review of study designs, tutors' notes, and seven 'sessions', with materials for small group learning sessions designed to last about three hours each. The first five sessions contain clinical scenarios, a reprint of a paper, critical appraisal checklists (with a useful crib giving the answers to calculations), the session expressed as a CAT (critically appraised topic) and exercises on question forming or searching. Therapy, diagnosis, prognosis, harm, and systematic reviews are covered. The final sessions cover presentations of participants' own clinical problems, net surfing, and feedback.

Are they useful to GPs? The scenarios are written from a secondary care viewpoint but could easily be adapted for primary care. The papers are all interesting and most are relevant. Unfortunately, they are slightly reduced in size, so you may experience some eyestrain. The books seem expensive, but the cost per session is only £4.30, which is not excessive (although you'd need a copy for each participant).

However, like model kits (which come without glue, paint, brushes, or expertise) these EBM kits need a few extras: standard texts by Sackett[1] or Greenhalgh,[2] an overhead projector, flip chart, Internet access, the Cochrane Library. Most of all, you need protected time, enthusiasm, and a facilitator who understands EBM. If you have some of these (especially a facilitator), these books are excellent and convenient resources for small group EBM courses.

Toby Lipman

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Management of drug users in the community
Edited by Roy Robertson
Arnold, November 1998
PB, 420pp, £19.99, 0 34070013 0

Forbidden Drugs (2nd edition)
Philip Robson
Oxford University Press, 1999
PB, 286pp, £12.99, 0 19262955 7

Writing as a GP who has made (almost) all possible mistakes in the management of drug users over the past 15 years, my first thought about Roy Robertson's book is that I wish I'd been able to read it 15 years ago. Perhaps, then, the transition from the misguided optimism of one who thought drug dependency could be cured by detoxification to my current, sadder and wiser, (and more clinically effective) state would have been easier.

Robertson's humanity and insight is well expressed in his introduction and chapter on detoxification. Evidence (often of poor

My Uncle's Illness

'Hitler,' my uncle said, 'made gentlemen out of the world:
it was after the War we got electric, radios and cars!'
And he should know it well enough, getting up at four a.m.,
driving stock ten miles in rain
and waiting for the cattle train.
(The War, fuel shortages, the fireman coaxing
the engine to steam on timber and turf).

We gaze at a half empty shed,
remember hay, turnips and grain:
'The trouble we had with all those bales!'

And after sixty cycles of ploughing and threshing,
Uncle stares into his own mortality;
asks questions over valves and arteries and veins,
while I explain: 'the nitrate spray
works underneath your tongue,
not down your throat or up your nose!'

But this being rural Ireland, Uncle has his guests:
a stream of ageing men with addled brains and addled backs.
First comes Pat Matter, stooped low, supported on a stick
fulfils the Sphinx's rhyme; then brother Martin,
wits to the wind, 'I left a bill hook in a ditch —
have you a spare that I could loan?'
Starts talking of a missing heifer,
goes home errands forgotten;
iron-shod wheels grind off the road,
the Pony Man ties up his cart,
and hauls his stiff legs through the kitchen door.

We have an hour for lunch
and counting four cars pass by the house,
Uncle ponders why the road's so busy on this day.

Alan O'Rourke

quality in this field) is blended with clinical experience in this practical guide. Don Des Jarlais gives a clear description of the history of recreational and dependent drug use, and delineates the standard approaches of governments: 'traditional values'; 'the war on drugs' and 'harm reduction'. Each of these approaches has consequences for patterns of drug use and the type of treatments (or lack of them) available to people who have found themselves having drug-related problems. The consequences of GPs taking up similar stances can also have implications for their patients and communities.

The chapter by Judy Bury and Carl Bickler gives a wealth of practical prescribing detail to the GP wishing to help patients detoxify or to provide maintenance therapy. I have a few points of disagreement with some of their approaches. There is perhaps too little discussion of the efficacy of high dose methadone prescribing in patients continuing to inject heroin, and the pre-requisite for this type of therapy, supervised dispensing. The recommendation of carbamazepine as a useful drug for the prevention of benzodiazepine withdrawal seizures is reasonable, but carbamazepine lowers serum methadone levels in methadone-maintained patients and can lead to a resumption of heroin use. Valproate is a better drug in such circumstances. Similarly, chloral hydrate is now known to be a highly dangerous drug for the treatment of insomnia in poly-drug users.

I was hoping to get some useful practical tips from Eilish Gilvarr's chapter on psychiatric aspects of illicit drug use, but found relatively few. Perhaps this is because making diagnoses in patients with concurrent mental illness and problem drug use really is fearsomely difficult. Nevertheless, Gilvarry presents a comprehensive review of the epidemiology of co-morbidity and she makes a point which is so easily forgotten: never forget to ask about drug use in patients with mental illness and never forget the possibility of mental illness in drug users.

Robson's book, *Forbidden Drugs* gives a very easy read. This second edition now includes, logically, chapters on alcohol and tobacco. He writes with (usually) gentle humour, use of anecdote and a clear style. He has provided me with a very rare (perhaps unique) experience: reading a medical textbook without having to take a break. Most drug-using patients do not present to GPs with problems relating to their drug use. This generally only happens after a long career of using heroin, cocaine, amphetamine, tobacco or alcohol. In some such cases, we can offer help. It is easy to forget to ask why patients start to use drugs in the first place, and Robson presents a clear picture of the pleasurable or 'mind-expanding' experiences people report when starting a drug-using career or engaging in recreational use. He provides a wealth of detail concerning presentation, street prices, modes of ingestion, metabolism and physical and psychological effects of most drugs encountered in the UK, and some which are at present rarely used.

The final section of the book deals with the nature of addiction, practical approaches to helping the drug user, and a discussion of the politics of drug regulation. Almost every practitioner (or politician) will find something to criticise in these chapters. This bears testimony to the fact that the author does not shrink from dealing with difficult and controversial issues. Although the author's personal views are discernible, he gives a refreshingly balanced presentation of the arguments and humbly admits to areas of real uncertainty. Anyone wishing to understand drug use and its consequences would do well to read this book. Sadly, policy-makers will probably be the section of society least likely to take this opportunity.

Philip Wilson

Making Sense of the Private Finance Initiative
Courtney Smith
Radcliffe Medical Press, 1999
PB, 211pp, £27.50, 1 85775381 X

The private finance initiative (PFI) arose from the last Conservative administration's desire to introduce market disciplines to the public sector and to obtain private capital for the construction of new roads, schools, and hospitals, thereby reducing the immediate need for increased capital spending by the Exchequer. The concept was enthusiastically adopted by the present Labour administration and is the preferred method of funding major new public sector projects, including the 'largest new hospital building programme in the history of the NHS'. The scheme has the most irresistible attraction of 'buy now, pay later'; the public sector borrowing requirement is not raised, and the electorally unattractive spectre of increased taxation is postponed.

Courtney Smith's book provides a useful introduction to the complex mechanisms involved in bringing a PFI project to fruition from strategic outline to final business case. The book is inevitably concerned with process rather than the end product; the former is primarily financial and legal. As expected from an economic advisor to the NHS Executive, the book is strongly pro-PFI. Such projects have 'the potential to offer colossal (sic) benefits to both parties' (page 8). Discussion of the planning assumptions underpinning new NHS hospital building is rudimentary. Criticism of the large reductions in bed capacity (about 30%) involved in all PFI projects for new hospitals is dismissed as a failure to appreciate future advances in medical practice (so-called hospital re-engineering). Current problems of rising emergency admissions and the increasingly obvious inadequacy of current acute hospital capacity are not discussed. The need for adequate needs assessment rather than financial criteria as a basis for assessing new hospital capacity, and the importance of adequate post-acute and community planning are unmentioned. The most useful skills in negotiating the Byzantine complexity of the PFI projects are financial and legal. Clinicians are not required until the last stage of the project when they may be required to validate (like turkeys voting for Christmas) the reductions in bed capacity and staff budgets required to make the project financially viable.

The most refreshingly honest section of the book is contained in the first of two case histories, by the Chief Executive of Calderdale NHS Trust, who described the difficulties experienced in bringing a first-wave PFI project to fruition. The horrendous administrative, financial, and legal problems included meetings at which lawyer's fees cost £3600 per hour and instructions from his District Health Authority to reduce bed numbers to ensure viability (so much for the 'doctors decide the bed numbers'). His description of the mass of signed legal documents at completion, which filled several crates in the lawyers' offices, makes chilling reading.

The text's concern with process obviates objective discussion of the major issues involved in PFI funding of public sector projects. These include the need to fund the NHS adequately from general taxation, overwhelming evidence that acute hospital capacity is inadequate to meet current and future demand, and the long-term consequences of locking acute trusts into a 30-year time scale of repayment. These inflexible long-term contracts take no account of unforeseen developments in medical care and, as the 'largest building programme in the history of the NHS' progresses, will generate massive repayments for a future generation of taxpayers.

The general practitioner who wishes to obtain a broader perspective would be better advised to read the four articles on PFI written by Professor Allyson Pollock and her colleagues in the *BMJ* between 3–24 July 1999 (the reviewer must declare and interest, having been a co-author of one article). While the present book provides a useful primer to those involved in PFI projects, it cannot be recommended as a balanced and objective guide to a major shift in public sector funding policy whose consequences remain to be evaluated in the longer term.

Mathew G Dunnigan

21st century glossary...

genome service provider,
formerly **parent**
Rory Harden, in *Prospect*, February 2000; page 7
Further submissions welcome, to
Journal@rcgp.org

A Gesture of Reconciliation – after 61 years

'The University of Vienna School of Medicine is an Equal Opportunities Employer and strictly opposes discrimination based on origin, race, colour, gender, or religion. The University of Vienna School of Medicine and its employees strongly endorse the international standards for humanitarian rights, detest racism and xenophobia, and are distinctively aware of their historic responsibility, specifically in the active battle against racism and any form of prejudice. Furthermore, the University of Vienna School of Medicine will not only continue but also intensify the actions it has consistently and actively taken during the past years to ensure that racism and prejudice are not tolerated.'

The Times, 11 February 2000

It is a little hard for me to understand why it took 61 years to apologise to Dr Fleming. Maybe it has something to do with the fact that, until recently, history at Austrian schools was only taught until the end of World War I. But it is better to apologise late, than never.

And now that we have a new government in Austria, things concerning Austria's NS history will improve. That is, at least what the leaders of the two ruling parties were forced to sign before taking over power. I wonder why it was necessary to sign such a paper?

Was it because one of the parties is extreme right wing, not to say fascist? Was it because the head of the right wing party, Jörg Haider, is also known to have warm feelings for Nazi Germany, addressing SS veterans during a public meeting as 'friends' and 'honourable people', calling Nazi concentration camps 'correctional facilities' and praising Hitler's 'employment policies'?

Haider is not Hitler and he is not dangerous, at least at the moment. It is rather what he stands for: he is the leader of a successful political party that is again legitimising nationalism and fascism.

Austria is one of the richest countries in the world with an extremely high degree of socio-economic equality. Why did one third of Austrians vote for a party with fascist ideas and why is another third not worried if such a party is in power? What is wrong with that country?

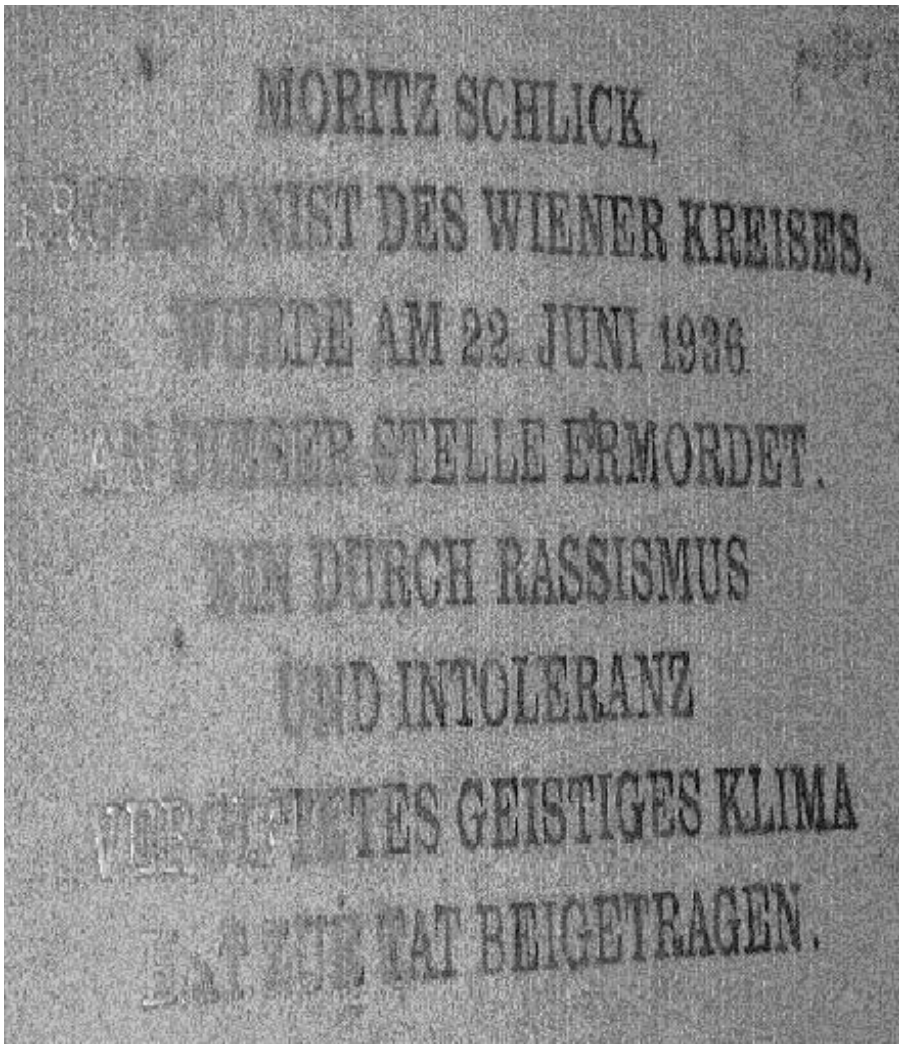
Anonymous
Vienna, February 2000

Increasing social awareness since the beginning of the 20th century led to a search for better ways of medical care. The underlying idea was the improvement of the health of the population. In time, different systems were developed in Europe, ranging from sick funds, usually trade union-based, to universal care. Whatever the system, care of the most vulnerable, the elderly, the disabled and the poor, was seen as a basic need.[1]

A very different philosophy was introduced by the Nazis in Germany. According to this, the task of the medical profession was to promote the health and breeding potential of racially pure Germans, since only they could fulfil the mission of the German people and defend it against inferior races; i.e. the rest of humanity. In support of this notion, certain 'inferior' groups were targeted. Those suffering from hereditary diseases, the feeble minded, schizophrenics, sufferers from manic-depressive illness, congenital epilepsy, hereditary blindness and deafness, any serious deformity, and serious cases of alcoholism were to be sterilised. Soon prostitutes and people with criminal tendencies were added to this list.[2] In due course, the term 'extirpation' replaced sterilisation.

The Nazis came to power in Austria following the 'Anschluss' in 1938. Immediately after that, it came as a great shock when the Nazis straight away imposed their strange ideas upon the medical profession. Professor of Anatomy Eduard Pernkopf, a fanatical Nazi, became Rector of the University of Vienna and left nobody in doubt as to the intentions of the new regime. He dismissed about 67% of the medical faculty, the majority because of their Jewish descent, others for political reasons. All final-year Jewish medical students, of whom I was one, were forbidden to take their qualifying exams and were expelled. Some Jewish students from the previous year who had not quite completed their finals were permitted to do so, provided they could do it within six weeks. Those who succeeded were taken to a windowless room and handed their diplomas, albeit with an endorsement stating that they were not permitted to practice in any German territory.[3]

I was reminded of all this when I received an invitation from the Dean of the Medical Faculty of the University of Vienna to attend an 'honorary' degree ceremony at the University on 4 October 1999. (After some



'Moritz Schlick, protagonist of the *Wiener Kreises* was killed at this place on June 22, 1936. An intellectual climate poisoned by racism and intolerance made this possible ...'

difficult years, and four years' service in the British Army, I eventually qualified from St George's Hospital Medical School in London in January 1949. I am now retired after a lifetime in general practice). After recovering from the surprise of this sudden invitation I found that an old friend and fellow student, Dr Shamir, now a retired paediatrician in Jerusalem, had also been invited. Both of us were glad to accept and I eventually undertook the long train journey to Vienna. My state of health does not allow me to fly.

As I walked up the many steps towards the University's Great Hall I recalled the vicious attacks Jewish students had suffered in the 1930s from their anti-Semitic colleagues; on these very steps one Jewish student had actually met his death and this is commemorated by a plaque set into one of the steps. It is understandable that I entered the Great Hall with mixed feelings.
In the Great Hall, Dr Shamir and I met with four other graduates, survivors of that group of doctors who had qualified but had been forbidden to practice, all of us accompanied by our families. We then foregathered in the Senate Room where we met the Rector of the University, the Dean of the Medical Faculty, and other members of the academic staff. We were then led in procession into the Great Hall. After the Dean's speech, in which he summarised the dramatic life stories or the six doctors, whose ages ranged from 84 to 88, the Rector gave a moving address. He apologised on behalf of the University for the injustice that had been done to us 61 years ago and said how happy he was to be able to do so. The ceremony, he added, had taken advantage of a 'window of opportunity that might close again'. A day earlier the Austrian electorate had ended 30 years of social democratic government, and less liberal parties seemed likely to replace them.

Following the speeches we swore the traditional academic oath over the ceremonial mace held by an usher and then the Dean presented each of us with diplomas showing that we were Doctors of Medicine. After this, at the end of the ceremony, I was given the opportunity to reply on behalf of the graduates; in my reply I expressed how gratified we were to see that the Medical Faculty had overcome the shameful episode in its past and that we trusted that it was now regaining its former world-famous position.

All of us were much impressed by the warmth of our welcome and were glad to see that the traditional Hippocratic ethos prevailed once more.

Otto Fleming

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berger 1

Photocopies
John Berger
Bloomsbury Publishing, June 1996
HB, 180 pp, £13.99, 0 74752505 6

Photocopies initially seems an odd name to give to a book of 29 stories which first emerged as a radioscript, in German translation, for the *Frankfurter Rundschau*. Yet as well as being the author of *A Fortunate Man*, that grainy existentialist account of a country doctor's life (and the book most doctors will know him by), Berger has always been interested in 'ways of seeing' — in how technology, especially photography, changes our perception of the world and our place in it. Photography makes strange by presenting us with end-objects that fix experiences never actually arrived at. By extension, photocopies exist in an even less person-linked domain of memory: They are reproductions, generally of things we don't own, like books.

There is a strong impersonal sense of lives — rather than books — taken a page at a time in *Photocopies*, from the ghostly pinhole camera photograph of Berger and a woman friend which precedes the first story, 'A Woman and Man Standing by a Plum Tree', to the last, 'Subcomandante Insurgente', a sympathetic account of present-day Zapatista peasant rebels in Mexico and their struggle against neo-liberalism. Rarely longer than six pages, each presents a scene from a life, or meditates on a story told. Landscapes, like the prose, are bare-boned: the Greek islands, Spain, or the French mountain village where Berger lives. The best story is a visit to meet Henri Cartier-Bresson, the most famous living photographer. Oddly, Berger neglects to ask him outright why, 25 years ago, he renounced his art of capturing 'things that no longer exist' (Proust). Perhaps the answer isn't difficult to guess, now that image and text are part of an extrapersonal utopia in which nothing can be forgotten.

Berger's understated method of entering the mind at work offers a parallel with the focus that patients sometimes offer us into their lives beyond medicine. One story concludes with the resonant, 'Nothing in a life is lost, the Curé said', which harks back to the humane economy of his 'fortunate man'. It is a definition of old-time memory. At times you can even hear its silence — between the photocopier's dazzlingly glib negations.

Iain Bamforth

berger 2

A Fortunate College
The John Hunt Lecture, 27 January 2000

The President introduced John Berger as our John Hunt Lecturer with Sir Denis's trademark sense of occasion — a cocktail of sanctity and imminent crisis. It was not an inapprpriate introduction. The man who bounded onto the platform seemed at once to reassure and threaten: a Picasso perhaps, or a Hemingway or a Cassals. Big, built like a bull, romantic; bohemian, even, in his open necked shirt, he grabbed the mike and roamed around like a beast sniffing the air for his prey.

'If you are going to wear a white shirt don't put on a red vest underneath.' The audience tittered nervously. 'This is what you say to a child of six?'. He paused, seeking agreement. 'And to a seventy-five year old man'. A powerful fist shot out to a woman in the front row, and then stabbed at his own barrel chest: 'That is what she just said to me'. And there, in the brilliant economy of this less than classical opening to a College grand event, the whole thesis of the evening was laid out before us: continuities, intimacy, surprise — the essence of general practice.

He thought the term 'general practice' important and good. The word 'practice' was warm and open: 'theory' was a cold and closed word. There was no script, only a table set out with open books and papers, which he picked up, examined as though he was somewhat puzzled to find them there at all, and he read from them. He read poetry by poets I had not heard of before, but ached to read now. He told tales as terrifyingly true as any ghost story.

We were offered no title, no tidy shape, no neat thesis and antithesis, no linear argument. There was, though, something disturbingly familiar about what was going on. Recognising the style was a shock: Berger was an anatomy demonstrator, holding up for our instruction specimens preserved from a long discipline of looking, listening, and imagining. What had been dissected for us here, however, was not a dead body, but a life.

Afterwards at the drinks reception there were sheepish grins of incomprehension on some faces and looks of wonderment and gratitude on others. I thought it a rapturous celebration of our deepest virtues. These are uncomfortable times. But in having John Berger as our millennial John Hunt Lecturer we can count ourselves a Fortunate College.

Marshall Marinker

uk council, january 2000

College Budget for 2000–2001 and Annual Subscription
Council approved the budget for the next financial year. This is based on an increased full subscription of £306, together with increases in other subscription rates. These increases are necessary to fund the effects of the sharp increase in locum rates and to meet regulatory commitments concerning contributions to the staff pension scheme. This will also allow four key projects go forward:

- revalidation Working Group — to continue the vital work of this Group with the intention of proposing a system for revalidation by January 2001;
- essential works at Princes Gate, especially to comply with health and safety requirements;
- further GP registrar visits to the College; and
- the electronic *British Journal of General Practice.*

Council also decided to conduct a review of the base budget, including faculty funding.

Supporting Doctors Protecting Patients, Future of Professionally Led Regulation, Revalidation* and *Good Medical Practice for GPs
Following extensive debate in November, Council considered the formal response to *Supporting Doctors Protecting Patients*. The College's initial response had been widely circulated in early December and had received considerable support.

Council agreed that the response should be submitted in the name of the College but in conjunction with the GPC, which wishes there to be a single response for and on behalf of GPs in England. The Joint Committee also wishes to join with the College and the GPC in its response. The College's Patient Liaison Group (PLG) will consider the draft in early February and, subject to the views of that Group, it is hoped that the final response to Government will be jointly from the three GP bodies and with the endorsement of the PLG.

The future regulatory framework seems certain to rest on appropriate standards and a system of revalidation. You will be aware that two key documents were launched at the beginning of this month by the College jointly with the General Practitioners Committee of the BMA. These are 'Good Medical Practice for GPs' and 'Revalidation for Clinical General Practice'. Copies have gone to all GPs, whether or not they are members of the College, and I am pleased to report that both are receiving strong support with a spread of helpful comments. I am very keen for all GPs to be encouraged to respond using the faxback sheet provided so that the College has a real feel for the views of GPs on these proposals. The comment period ends on 31st March 2000.

Strategy for Supporting Clinical Governance
Together with Vice-Chairman of Council Mayur Lakhani, I presented a paper on the College strategy for supporting clinical governance in England and Wales and, in particular, how the College should position itself in order to:

- influence policy as it emerges;
- support its members; and
- take a leading role in raising standards across general practice,

As clinical governance is about co-ordinating a whole range of quality processes and managing them effectively, the College must also manage its work on clinical governance. We suggested in the paper that the College should consider setting some milestones against which the College can measure its contribution to clinical governance and evaluate it. This is likely to involve those activities which are UK-wide or cover more than one country of the UK; for example, the St Paul RCGP Quality Unit covers England and Wales; the Dame Annis Gillie Programme is UK-wide. There is also a clear role for faculty work in those areas and consideration should be given as how best to exploit the opportunities for faculties in clinical governance.

Council was supportive of the paper and it will form the backdrop to future debates on clinical governance and related issues.

Working Group on the College Constitution
The Working group presented its first comprehensive report to Council which invited Council to consider four main issues:

- that there should be a UK Trustee body for the College smaller than the present College Council;
- that there should be a country Council for each of the four UK countries developed from the successful Councils in Scotland and Wales and the proposals being developed for Northern Ireland;
- that the role of the President should be reviewed such that he or she should become that of the Chair of the UK Trustee body as well as retaining the current ambassadorial functions; and
- that each country Council should be headed by a Chairman who would, within the area covered by the country, carry similar roles to the current Chairman of College Council.

Council thanked the Working Group for its work to date and was keen that discussions continue on several key issues. The Working Group will now examine these issues with a view to reporting further to the March or June Council meetings. One of the questions to be considered is the form and style of the formal consultation process. In the

Annual General Meeting
The AGM, to be held on 17 November 2000 is the annual opportunity for all members to attend a general meeting of the College. In the past, the College has been pleased to welcome members visiting from the UK and overseas, founder members, Honorary Fellows and Past Presidents.

As well as the formal business of the meeting, this is a family occasion for those attending the presentation of College awards and election of Fellows. This year it is expected that around 140 Fellows will be elected to Fellowship.

The James Mackenzie this year it is to be delivered by Professor Per Fugelli. Members and their guests are welcome to stay on for the lecture.

The business part of the AGM follows the lecture and is open only to members of the College.

If you are considering attending the AGM then please let us know by no later than 1 November 2000. Any motions which have been raised by College faculties or others will be considered in the business part of the meeting. Resolutions not on the agenda may be discussed at the AGM but not voted on if they involve an alteration to the Ordinances or the Byelaws. If you need more information, please contact Dr Maureen Baker, Honorary Secretary to Council, via the Clerk to the Council.

meantime, informal consultation can continue by means of the electronic forum on the College's website.

Two associated papers were also approved. The first was to hold a one-day conference of English faculties to act as a forum for consultation and development of the proposals for sub-national representation in England. The second dealt with guidance for candidates for the Presidency; the successful candidate will of course assume the role in November 2000. During the period of office, it is possible that the role of the President could change to reflect the proposals in the main paper as reported above. That would of course be subject to final approval by Council following a full consultation exercise and the necessary changes being approved at a general meeting of the College.

Role of Pharmacists in Primary care
Mike Pringle's paper examined the role of pharmacists in primary care and identified the College as having a key part to play:

- patient care is influenced by a range of health professionals, including pharmacists;
- general practitioners currently generate the vast majority of community prescriptions;
- prescribing is a key element of our work, its costs are substantial, and is used as a performance indicator; and
- as members of primary health care teams we wish to influence developments in primary care that may enhance patient care.

The paper examined the issues and offers models of three types of pharmacists — the community pharmacist, the practice attached pharmacist, and the pharmacist adviser. The development of these models within the remit of primary care will go forward in conjunction with the Royal Pharmaceutical Society, which is broadly supportive of the approach in the paper.

The debate produced some interesting issues about dispensing in different environments, the prospects for increasing the concept of practice-attached pharmacies, and the need for equality of access for patients to pharmacy services. The position of doctors who dispense drugs was also discussed. Mike Pringle will now refine the paper in the light of the debate and enter into discussions with the Royal Pharmaceutical Society concerning its conclusions.

Next Meeting of Council
The Third Meeting of the 1999–2000 Council will take place at Princes Gate on Saturday, 25 March 2000, commencing at 9.00am.

Maureen Baker

neville goodman

There will be a few sunny intervals but frequent showers are likely before lunchtime.

Does anyone claim not to understand this? Does anyone claim to be so puzzled by this statement that they would fail to realise they should take an umbrella out with them or wear a waterproof of some kind? It will surprise you to know that although lay people are fully aware of what *few*, *frequent*, *common*, *rare*, and other similar words mean, doctors in training don't understand them.

We are told that adverbs and adjectives of frequency should not be used in multiple choice questions. They make questions ambiguous, which is not fair to candidates. But is 'Haemoptysis is common after pulmonary embolism' (false) unfair? Is it any more fair to give a percentage incidence? One suggestion is that both these forms are taboo, which leaves only 'Haemoptysis is a recognised symptom in pulmonary embolism' (now true). This allows no distinction from 'Chest pain is a recognised symptom in pulmonary embolism', which is ridiculous. I once set a mock question about fluid therapy after burns, giving the anterior chest as 15% of body surface area. Most candidates, mesmerised by the 'rule of 9' into a rigid 18%, marked this as false and lost a mark. The 15% came from a book that used a different estimating rule, but what worried me was candidates' inability to realise that, in this context, 15% and 18% are not significantly (in the clinical sense) different. I suspect they would have marked 17% false.

Everything about examinations these days is concerned with being fair to candidates. Slowly and surely, litigation is creeping up on postgraduate examinations. While admitting that some examiners are bound to be harder than others, candidates' recollection of their own performance is gravely distorted. I met a girl who claimed she failed an anaesthetic examination because she could not list the muscles inserted into the mandible. I suspected then (when I was a candidate myself) what I know now (as an examiner): she may not have scored anything for muscles of the mandible, but she failed for giving an incorrect answer to a far more important question, without realising that her answer was wrong.

When these same candidates deal with patients, they'll find that some of them aren't 'fair' either. Patients complain of symptoms they haven't got to get the attention of doctors to symptoms they want to have. They don't realise the 'correct' way that diseases present. Examinations must not pretend that clinical medicine is clear cut. If that is unfair to candidates, blame it on the weathermen.

alan munro

Immortality

The American biotech industry expects to solve the 'problem', as they put it, of mortality in a couple of decades. Our grandchildren will be able to choose whether their children will be mortal or immortal, men or gods. So sayeth BBC2's *Horizon*. The programme consisted of a procession of white, Anglo-Saxon, vastly enthusiastic, intimately gesturing, frighteningly articulate and intensely persuasive apologists for the industry. All the time, at every turn, these fine young men and women, these unctuous midwives of an immortal master race, all smiled, endlessly smiled the radiant, calm, energetic smiles of flawless certainty. Not a troubled soul on the horizon. I restrained myself from leaping up with a 'hallelujah!' (Always getting the timing wrong.)

Mercifully, the programme makers did, just once, warily, tentatively, raise the issue of justifications, and were met with: 'If we don't do it, someone else will (get the profit)'. Full stop. Ah, fine, silly of me to wonder where all that certainty came from, I guess I quite forgot about the triumph of free markets and all that. In the closing sentence of the programme, consequences leapt into the frame, flickered less than momentarily, and died. Immortal tyranny was mentioned, just as a passing thought. Immortal tyranny!

Zeus Murdoch, Apollo Gates, Athena Trump, thunderbolts, and rape are not exactly what I have in mind for my great grandchildren.

* * * * * *

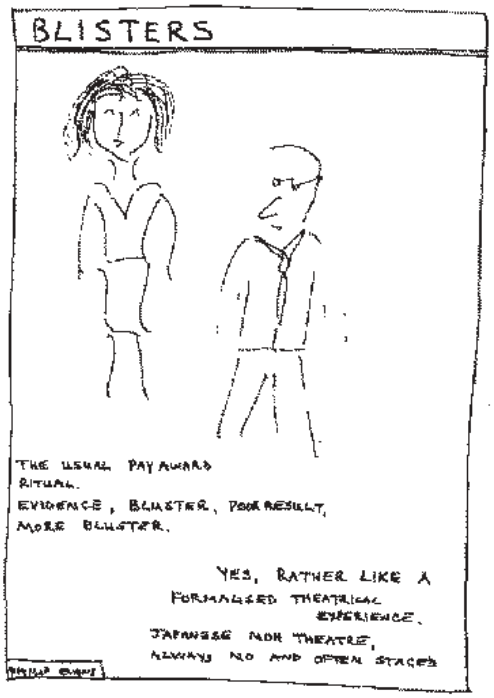
Edward Abby's *Desert Solitaire* is a gravelly polemic against the chromium and peanut butter culture, couched in prose as lacerating as the Utah sun, but at times as delicate as the song of the desert wren. His humour is laconic, as much gush as a drip from a canyon wall, but as vital and refreshing.

'… you are doomed. Comfort yourself with the reflection that within a few hours your human flesh will be working its way through the gizzard of a buzzard, your essence transfigured into the fierce greedy eyes and unimaginable consciousness of a turkey vulture. Whereupon you, too, will soar on motionless wings high over the ruck and rack of human suffering. For most of us a promotion in grade, for some the realisation of an ideal.'

This is like a Tibetan air burial. The Tibetan arrangements have the edge in that the vultures don't start until you are definitely finished. It is another kind of immortality.

* * * * * *

There are choices to be made in this the spring of the third millennium after Athens and the Buddha. The Greeks had institutions for making choices. Do we? Or have we administrative arrangements protecting the freedom of corporations to profit?



Blisters *... were a class of drugs used in the 18th century for seriously ill patients, especially those with fevers. They were usually alcohol solutions of powdered* Cantharides *beetles. When placed on the skin the irritative preparation caused a large painful blister. The humoral theory of that time considered that the irritative solution drew the foul humours into the blister fluid. So now you know ...*

Philip Evans

our contributors

Iain Bamforth reviews regularly for the *Times Literary Supplement* and the *London Review of Books*. He is a GP in Strasbourg, France. His wife is a health visitor who cycles to work each day in Germany

Mathew Dunnigan is a consultant physician and a Research Fellow in human nutrition at Glasgow Royal Infirmary. His cogent analysis of the number of beds needed at the new Edinburgh Royal Infirmary have won him few new friends on Lothian Health Board

Philip Evans practises in Bury St Edmunds

Otto Fleming is in his mid-80s. He was a GP in the mining community of Mexborough, South Yorkshire, for almost 30 years, and then in Sheffield

Neville Goodman is now a favoured confidant of *Private Eye*'s MD

Trish Greenhalgh combines command of jargons yet invented with earthy common sense (This tablet may save your life *BMJ* 2000; **320:** 455). Not many people can do this

Toby Lipman, a Newcastle GP, sounds like a spotty faced youth, but photographic evidence has yet to reach us. His passion for model aircraft construction and EBM is enlivened by more human enthusiasms, such as familiarity with effective naval strategy during the Napoleonic wars. Of which more anon ...

Steve Morris is a PCG prescibing adviser

Alan O'Rourke works in medical informatics and education in the Institute of General Practice, Sheffield University. He is married to a trainee medical herbalist, and spends spare time modelling and writing about Irish railways, and working two allotments.

Bruce Warner is another member of that burgeoning tribe, the PCG prescribing advisors, and additionally a community pharmacist

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