

# The British Journal of General Practice

## Viewpoint

### Revalidation, the GMC, and consultant angst

A split in the medical profession always makes good press, and the media have been quick to seize on the recent heated debates about revalidation and the role of the GMC as the latest example.

There is, of course, no 'split'; what has happened is that in proposing a uniform system of revalidation to cover the fundamentally different circumstances of hospital medicine and general practice, the GMC has created a garment that simply will not fit. We must now work hard to customise that garment to suit the wearers' differing requirements.

There is no difference at all between general practice and hospital medicine in our aims. Senior hospital doctors recognise the need for the regular and public reaffirmation of doctors' continuing fitness to practise; the CCSC last year committed itself to the principle of revalidation and has not wavered from that commitment. We also continue to support the concept of professional self-regulation. But as things stand there is widespread concern among senior hospital doctors about the practical impact that the present GMC proposals will have on our working lives and on our patients. Without significant amendment to the proposals and the thorough reform of the GMC the credibility of professional self-regulation is under real threat.

Our main concerns about the GMC's proposals for revalidation stem directly from the fact that, as consultants, we are salaried employees working these days in highly managed organisations. While our training and appointment is governed by professional requirements, our day-to-day work is largely determined by the priorities of our employers, the trusts; we have job plans, service objectives and departmental budgets, and are accountable for these, and now also for clinical governance requirements, within clinical directorates. And on top of that, at the instigation of the CCSC, we are now embarking upon a nationally agreed and contractually binding system of annual appraisal for consultants which will cover all aspects of performance in our jobs. All these developments are strongly supported by consultants.

This perspective highlights the apparent confusion in the current GMC proposals as to what revalidation is setting out to achieve. If it is a reaffirmation of continuing fitness to practise, i.e. of basic registration, we have no problem. However, revalidation also seems to focus on issues that are relevant mainly to performance in a particular job, or to general quality improvement. Teaching ability, contribution to management, effectiveness of teams, performance against Royal College guidelines — these are all extremely important, but we feel are matters more appropriately dealt with at employer level, through the organisational structures discussed above. They should not directly affect a doctor's continued ability to practise.

The proposed five-year reviews exemplify the problem. If, as we believe, the requirements of revalidation are essentially fulfilled by the process of appraisal, the five-year reviews can be little more than a rubber stamping exercise. In this case the time and expense involved in assembling groups and compiling documentation to revalidate 25 senior hospital doctors per day, year in year out, is hardly justified. If on the other hand the exercise is real, significant questions arise about the methodology of the revalidation groups, the robustness of the evidence contained in the folders, and the effect on a doctor of failure to recommend revalidation.

Of course the GMC has a vital role in quality assurance, but just as it oversees medical education without itself examining every medical student, surely it can oversee a robust appraisal and revalidation process without itself assessing every doctor.

I hope and believe that these concerns can be fully discussed and overcome. For senior hospital doctors I am convinced that the requirements of revalidation will be entirely met by a national NHS appraisal scheme and existing clinical governance requirements, overseen by CHI and the GMC. If the revalidation scheme can be flexible enough to meet the different needs of different groups of doctors, then the GMC will find that we can all move forward together.

**Peter Hawker**

*Chairman, Central Consultants Committee, British Medical Association*

## The Back Pages...

**“I looked after a patient with acromegaly for 15 years — saw her hundreds of times. The fact that she was very unlikely didn't make her only partly there. In fact, having acromegaly, she was rather more there than most people...”**

**Unlikely Incontinence,**  
James Willis, page 688

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### The European General Practice Research Workshop (EGPRW)

One of the aims of the European General Practice Research Workshop (EGPRW) is to promote high quality research in general practice in Europe. International courses on research methods are regularly organised. For more details of these, see the EGPRW internet site at <http://www.synapse.net/mt/egprw/>.

In addition, funding has been allocated to support the development of research ideas and projects. Individuals who have presented a paper or a poster at an EGPRW meeting are invited to submit proposals for funds to continue their idea or project. Funds are available for small individual research projects (up to 5000 euros) and for the development of collaborative multinational European research projects (up to 8000 euros).

*The next deadline for submission of a proposal is December 15th 2000.*

Details are available from the EGPRW secretariat in Maastricht [Hanny.Prick@hag.unimaas.nl](mailto:Hanny.Prick@hag.unimaas.nl) or from the UK representative of EGPRW, Hilary Hearnshaw, Centre for Primary Health Care Studies, University of Warwick, COVENTRY CV4 7AL. [Hilary.Hearnshaw@Warwick.ac.uk](mailto:Hilary.Hearnshaw@Warwick.ac.uk).

### Implementing National Service Frameworks in Primary Care RCGP workshop, June 2000

Ye gods! I had an idea that implementing national service frameworks in primary care was going to be a job. Quite how much of a job emerged at a workshop that I ran at Prince's Gate in June along with the Department of Health. This agenda heralds changes in practice performance that put the 1991 Contract in the shade.

Certain themes came up again and again. Information (or the lack of it), commissioning, and change management. Resources (surprise, surprise). Money, incentives, staffing, and skills. Our systems and working practices are nowhere close to the joined up working implied (for example) in the mental health National Service Framework (NSF). Collaborative working is also widely trailed to be at the core of the Care of the Elderly standard.

The problem is knowing where to start, and this was what the workshop sought to identify.

First, we need to know how much need there is in each locality, broken down by practice. We need to know what is already being done and then to show that we are doing it differently in the future. We need to be able to identify changes in health outcomes (for example, a local tally of young heart attack patients). Forget clinical audit, which asked one (fairly simple) question at a time. The NSF on coronary heart disease asks dozens of them, and demands that they be answered regularly. Doing this is a matter of collecting information in a standard way in computerised notes. And as we well know, doing anything in a standard way is antithetical to many colleagues.

Commissioning is a crucial task. If you are going to make changes in how services are delivered then you set your contracts accordingly. The NSFs are a recipe for quality practice (or at least that's what they hope to be). Commissioning on this agenda is going to require a quantum leap in the organisation and performance of PCGs and LHGs (Wales). Done well, the new commissioning could be a quality focused approach that applies across primary as well as secondary care, with social care waiting in the wings. The conclusions of the recently published Tracker survey don't raise much hope; PCGs are so busy inventing themselves that commissioning still bears a strong stamp of 'same as last year, with a little novelty on the side'.

Changing the behaviour of general practice is something that has been tried before, not always with happy results (remember Health Promotion Clinics? Kenneth Clarke does!). How are we going to persuade, induce or compel all general practices to do things, lots of complicated things, in standard ways, recorded in computer systems, regularly and reliably reported? The hawks would close every practice that didn't comply in fairly

short order and end up with a wasteland where those doctors jumped that hadn't been pushed. The doves would provide a generously endowed incentive scheme, an approach which can only be as effective as the incentive targets are reachable.

So is it going to happen? I think that the jury has hardly started its deliberations. One problem is the lack of evidence. For change on this scale to work throughout the service, we should at the very least know what works. And while there may be wide agreement on the need to address poor standards, there is as yet no understanding on what it is that makes practices and practitioners want to change. Without that ingredient, the rest is futile.

Joe Neary

### British Association for the Study of Headache (BASH) — [www.bash.org.uk](http://www.bash.org.uk)

Apart from those who suffer from migraine, most GPs groan at the mention of the word headache. Unfortunately, this response overlooks a number of important points.

Firstly, headache is very common. In any one year 70% of our patients will get tension type headache and up to 15% migraine. Chronic daily headache — headache that occurs on 15 or more days of the month — affects up to 4% of the population.

Secondly, headache disorders can be disabling and incur high economic cost and substantial personal suffering. The cost of migraine to the UK economy has been estimated at approximately £1 billion a year. Thirdly, despite the existence of effective treatments, the majority of headache sufferers do not seek medical help and treat themselves with over-the-counter medication. Fourthly, when patients do see their GP, their headaches are often poorly treated and mismanaged. Many chronic headaches are attributable to medication misuse, often prescribed by their GP!

The British Association for the Study of Headache is the professional body which seeks to raise the awareness of headache and improve its management at all levels. Its website ([bash.org.uk](http://bash.org.uk)) contains guidelines for both diagnosis and management. In an age of evidence-based everything, one of the features of this framework is an acknowledgement that there is little rigorous evidence on which to base the management of headache. Guidelines based on expert opinion and past experience come as a breath of fresh air in a market that is overlaid with efficacy studies derived from randomised controlled trials.

Headache causes a considerable degree of unnecessary morbidity and is poorly managed in primary care. Although time and listening are essential prerequisites not always available to the GP, a visit to [bash.org.uk](http://bash.org.uk) may just lighten the burden of sufferers.

David Kernick

## 'A Day of CAHHM'

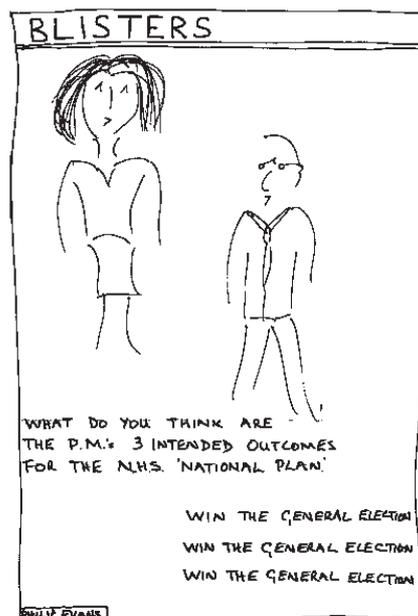
The launch of Durham's new Centre for Arts and Humanities in Health and Medicine (CAHHM), entitled 'A Day of CAHHM', attracted over 100 delegates from all over the country. The range of interests represented — from artists to anaesthetists — was vast, demonstrating the widening interest in the arts and health in this country. Guests attending included John Wyn Owen, Secretary of the Nuffield Trust, which is supporting CAHHM financially, Lara Ellen Dose, Director of the National Network for the Arts and Health, and Professor Michael Baum, Chair of the newly formed Institute for the Medical Humanities.

The conference was opened by Sir Kenneth Calman, Vice Chancellor of the University of Durham, who has a long-held interest in the arts in health and was one of the main drivers for the formation of the two national organisations represented at the conference. CAHHM has been formed to support the development of the new specialties of arts in therapeutic practice and community development, and of arts and humanities in the education of health professionals. After its first six months the Centre has plans for work in five main areas of research and development, including architecture and design of health service buildings, literature and medicine (a lecture series on 'Madness and Creativity' is planned), and music therapy. CAHHM has been funded to carry out an audit of arts and health activity in the Northern Region of England with a view to designing a research strategy and to understanding the educational needs of those who are working in this field. The Centre will also take a major role in the development of new medical curriculum in Durham. The University will be receiving 70 new medical students for two years of their training from October 2001, they will then complete their degrees in Newcastle. The Durham component promises to be different, in that it will involve arts input and the students' medicine in community course will be led by anthropologists.

The importance of the Centre's work on research on the role of the arts in combating social exclusion was discussed during the morning session, and in the afternoon there was a demonstration of how the arts can help people in isolated rural communities, urban deprived settings, and in hospitals. The final session was a showcase for Durham academics from English literature, philosophy, music, and social studies to explain plans for collaborative research with CAHHM in their disciplines.

The day was busy but very successful, and established CAHHM as having a broad range of activity and interests in the field of arts and health with, I hope, much to offer in the future.

Jane Macnaughton



This article is the eighth 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.

#### Scenario – Alfred Part 1

A 54-year-old man living alone in a city centre housing estate presented as an emergency appointment. He was dishevelled, said he felt very low and wanted 'some stronger tablets' to make him feel better. For one year he had been attending the psychiatrist with unresolved 'depression'; he was taking Prozac. His community practice nurse had advised doubling the dose of Prozac three months previously, but he failed to attend his last two appointments.

#### Alfred Part 2

Alfred had no previous history of psychiatric disorder. He clearly lacked self-esteem, but fortunately his self-motivation was intact. When asked for his opinion on his problem his reply illustrates why service delivery needs to change — with great emotion he stated "I want a job but no-one will give me one; they say I'm too old, and I can't write". Further questioning detailed Alfred's working life — mainly cleaning jobs, but with up to 15 years' commitment to a single company.

#### Alfred Part 3 — reflecting on the case

Society's failure to enable Alfred to find gainful employment had led to his prolonged social isolation and resulting medical dependence. His costly treatment had not improved his sadness and could have been better invested in other ways.

Communities suffering deprivation don't always appeal to new recruits into general practice. Yet the future for such traditionally demanding areas is undergoing a quiet revolution, slowly but surely gathering a critical mass for change. The revolution is a society change, led by the belief that communities suffering disadvantage are best placed to identify local needs and develop solutions to address their problems. So what is the future for local GPs and how do external influences on local demography positively influence practice? This article highlights some of the changes that I believe make areas with the greatest inequalities in health the places to practice in the 21st century.

The past decade has brought many changes for my Leicester inner-city practice, but the one constant is that the medical problems of society increasingly dominate workload. Daily, I sift symptoms to ascertain whether the problem presented is related to medicine, welfare, education, crime, social exclusion, or employment. While we sit on PCG boards, balancing our currently majority wish to remain independent agents with the need for ensuring competence in issues of clinical governance, disadvantaged communities are being rebuilt. They are being helped to develop formal structures for community development, utilising health statistics that were once the province of public health physicians and interested GPs but are now in the domain of the residents and their frontline workers.

Community capacity building and generating social capital aren't generally initiated by health bodies, but by local authorities. Their departments (often allied to Environment and Development departments) study various models of community engagement with the aim of developing the voices of what were previously regarded as isolated 'failed' communities. Cross-department co-operation in such authorities enables the development of joint training programmes in an environment of seamless service delivery. The aim of this training is to develop the skills at all levels of the public service workforce, with programmes facilitating new methods of working that are customer centred, professionally disciplined, provide best value for money, and are capable of managing change. Fine words, you might think, but how do they play on a busy Monday morning? In essence, these activities are the flesh and blood of government initiatives designed to tackle inequalities in health and reduce social exclusion. In my own city they have meant that I have had the chance to contribute to the Health Action Zone, the Education Action Zone, and the New Deal for Communities. This experience has brought statements such

as the following, by John Denham, to life: 'consulting the public will become our normal way of working and community involvement will be integral to the development and delivery of services.' I no longer see them as pious irrelevances but as real opportunities to tackle the root causes of so much of the distress that we see in every surgery.

This change in view needs to start early. In Leicester, preparation of doctors for working in the modernised NHS begins with medical students learning as 'guests' in the community and patients seen both as experts in their own non-medical problems and as partners in managing their own care. All Leicester's medical students are immersed in communities, particularly where inequalities are greatest, to understand health in the context of the demands on people's lives. They learn alongside nursing and social work students, meeting the range of organisations that impact on people; they are required to produce multi-agency solutions to patients' identified problems and contribute to the development of integrated service delivery in these communities. This shared learning provides a unique opportunity to appreciate the knowledge and skills of allied professions, and seeks to encourage the development of multi-disciplinary teamwork.

The outcomes of such exposure to 'real life' impact on the patient, frontline workers, policy-makers, and on the students themselves. For example, a patient who was lacking in confidence, distressed by her illness, and saw no future became involved in the student programmes. Afterwards she stated that her sense of self-worth and confidence had improved and she is now the lead figure in instituting the inner-city estate's first neighbourhood watch scheme. Another patient, who suffers with a severe chronic disability, was deeply unhappy with her compulsory re-housing; after interviewing this patient the student group met with the housing manager and pressed for a solution that resulted in the patient being happily settled in more suitable accommodation. The housing manager stated afterwards that 'the students' questions and insights have encouraged me to re-examine our priorities and practices, which is no bad thing.' Medical students contribute to the professional debate on tackling inequalities in health and have forged links with the Chairman of the Health Authority and local government.

Will this training influence the development of the 'doctor of tomorrow'? Leicester students have embraced the opportunities that these courses provide by becoming involved with city-wide regeneration

projects; for example, supporting the Leicester Sure Start programme. It is too early to demonstrate the impact of this multi-agency training on the professional behaviours of future doctors; however, since the number and range of such training programmes is rapidly expanding through United Kingdom and European medical schools it is only a matter of time before the picture becomes clearer.

How will such an approach affect Primary Care Trusts or Local Health Care Co-operatives? I believe that Primary Care Trusts will, with public involvement, develop performance indicators that reflect broad components of social and environmental wellbeing. Communities will expect doctors to deliver health services in collaboration with a network of local services designed to deliver evidence-based, good practice. For example, pre-school children's health services will be integrated with early years education and welfare. Children's preparedness to enter school at the age of four years will be a key measure of good community practice, and will reflect the quality and unity of preventative, health, and education services.

The GPs embracing these changes will thrive; their teams will be better supported and will benefit from the advantages of working and learning together. Recognition that health intervention is only a small part of the overall equation of health gain in disadvantaged communities enables the development of evidence-based interventions that can be budgeted and locally delivered.

The core of all this is realising that public health is not some dry-as-dust discipline practised by distant others, but a key skill of the new primary care. Just as general practice's great strength has been to blend scientific medicine with individual meaning and humanity, so our great contribution to public health will be the ability to make the insights of epidemiology come alive for our local communities.

The benefit of such an approach is clear: traditionally, the only thing I have been able to give Alfred is Prozac — and both of us know that this is not the solution. For Alfred the answer lies in social inclusion, giving him back his role in society. For me it's about seeing the city's inward investment strategies and collaborative working pay off locally. In practice this means helping to create better services, more articulate communities, more people in work — and moving from being overwhelmed by demand to helping communities create a better future.

Angela Lennox

### The way of all flesh?

What happens to medicine when our ability to alter the flesh is no longer mandated by some underlying pathology? Tattooing, body-piercing and cosmetic surgery treat the body as a fashion accessory, Viagra dwells in a twilight zone between therapy and sex aid, and the one million people who regularly swallow ecstasy do not think of themselves as ill. These are all early examples of recreational therapies — interventions that are no longer based on the depredations of disease but are choices mediated by consumer capitalism. As bioscience extends its dominion over the flesh, new possibilities explode. Recent advances in computerised eye scanning, for example, are just beginning to produce devices that can routinely improve on 'perfect' 6/6 vision by correcting for the microscopic defects that exist in the cornea and lens of every human eye ([www.wired.com/news/medtech/](http://www.wired.com/news/medtech/)). Contact lenses built around this technology will show users the world in 'unnatural' but probably pleasant and useful clarity. Such advances mean that the word 'prosthesis' will no longer be corralled with 'disabled' but will come to mean a chic and powerful augmentation that extends the range of physiological possibilities. And alongside these physical bionics the genomic brew is dreaming up radical new plasticities for the human form.

Such choices will clearly involve doctors since medicine is intrinsic to much of the technology and doctors are culturally best placed to purvey these new manipulations of the body. But they involve a stark departure: increasingly large parts of medicine will become decoupled from death and disease. Doctors may find this harder to accept than patients — dethroned from fighting death, we may feel demeaned by becoming purveyors of mere lifestyle choices.

[hodgkin@innovate.org.uk](mailto:hodgkin@innovate.org.uk)



**John Holliday, Isle of Tiree ...**

*'I was born in Essex, spent most of my youth in Norfolk, and after studying science at Cambridge University, went on to study medicine in London. I've always had an interest in remote places and I spent a number of years looking after aboriginal people at Kintore, an isolated practice in Australia, about 800km from Alice Springs. My son was born in Alice Springs Hospital but we decided we couldn't live there long-term.*

*'When we came back to this country I couldn't settle down, but I then got the chance to come to Tiree. I'd gone on holiday on several occasions to the north west of Scotland and my first hospital post after graduating had been in Fort William.*

*'The island of Tiree is about twelve miles long and about two or three miles wide and, although I only have 750 patients, I do a lot of driving to visit people at home. I'm extremely happy working here; the people are very polite and undemanding. You'll get a patient coming in on a Monday morning and saying "I had chest pain all weekend", or "I had an epileptic fit on Saturday night but did not want to call you out at the weekend".*

*'The size of the practice is a balance between being small enough to spend time with patients but large enough to be presented with the usual variety of medical problems. You have to keep on your toes and there are exciting times when the plane can't get in and you have to manage burns, set fractures, and do minor surgery which would otherwise have to go to hospital. One of the features of the island is that there is a good air service to Glasgow which is where I tend to refer patients requiring hospital care. I don't get very much time off and even with the Associate Practitioner Scheme I find myself just finishing seven weeks on-call before getting a break.*

*'The Gaelic language is still quite strong among the older people and I have worked at becoming reasonably fluent in the language. My wife and children both speak Gaelic but don't use it very much. I have a lot of interests outside medicine, with music being particularly important to me. I co-founded a traditional music teaching festival which now is in its tenth year and we have about a hundred children attending every year. They are taught a mixture of musical instruments, dancing and singing and it has helped a revival of traditional music and arts on the island. My main passion at the moment is setting up a museum to reflect the history of the island and we have raised money to buy a building so that people who visit here can learn about the island's traditions.'*

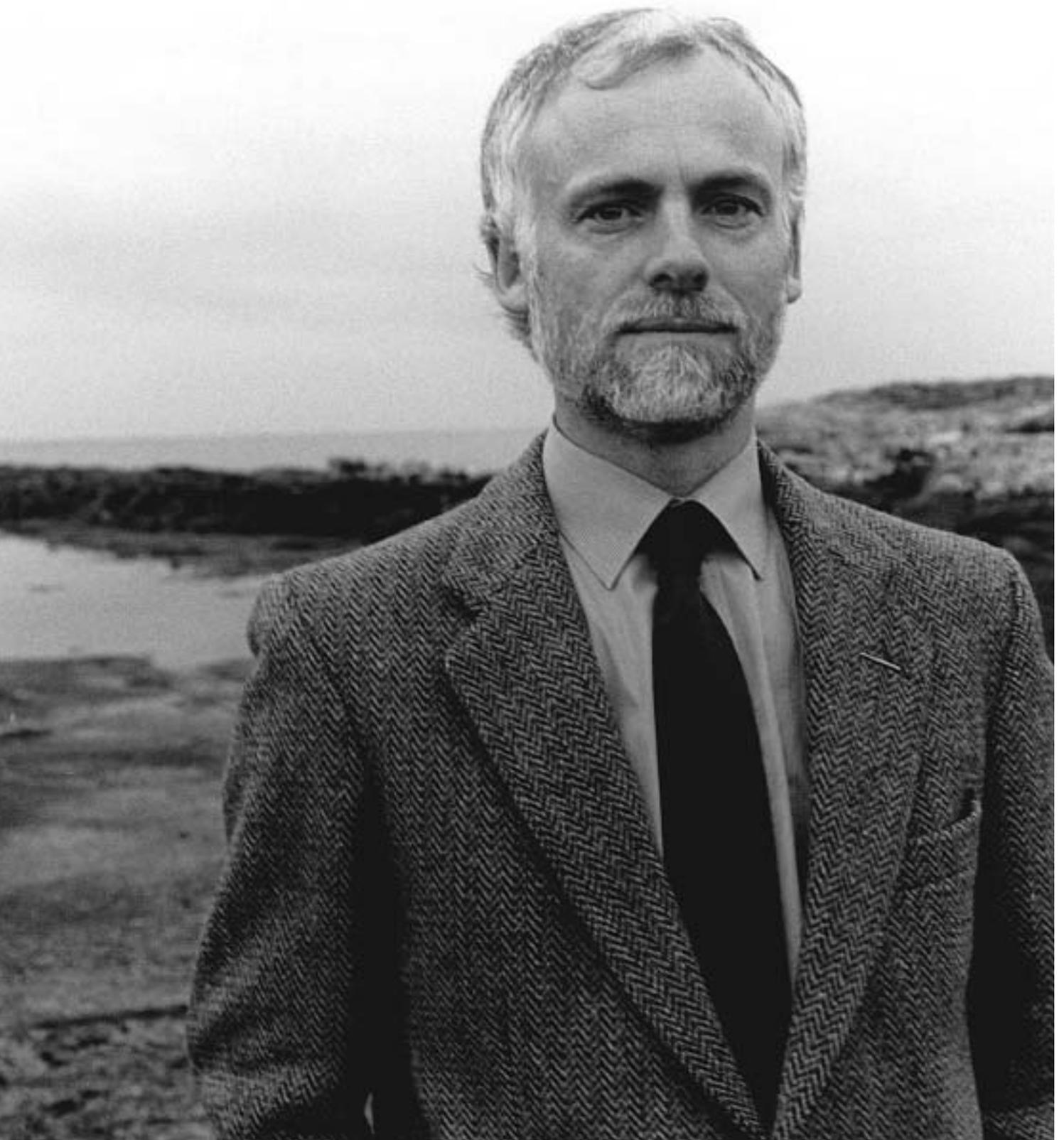


**Rosie Donovan**

**London Ontario, Canada... [www.rosiedonovan.com/](http://www.rosiedonovan.com/)**

*... from Single Handed: General Practitioners in Remote and Rural Areas of Scotland, commissioned by Single Handed was first shown in London Ontario at galleries@ the galleria, last winter, moving to Scotland. Single Handed opened at Glasgow's Kelvingrove Art Gallery and Museum on 4 July (until 3 September). Other venues will be confirmed soon, and the book of the exhibition is in press.*

**Technical - Camera: Nikon FE; Lens: 36-72mm; Film: Agfa APX 100; Paper: Agfa Classic**



Professor John Bain, of the University of Dundee, a photographic and sociological study of GPs in remote areas of Scotland. tland for the RCGP Spring Meeting, 2000, Crieff. er). Other dates include **Nairn** (the Inducement Practitioners Conference) 10–12 November , and **Kingussie** 17 November – 8 December.

## Liaisons Dangereuses — A Conspiracy Exposed

Despite considerable fears for not only my research career but my personal safety, I am obliged to expose through the pages of this journal a conspiracy that I have uncovered of utmost importance to the development of primary care.

Medicine has been described as a few things we know, a few things we think we know but probably don't, and a lot of things we don't know at all. The evidence-based medicine (EBM) movement arose in part from a recognition of the large variation in clinical practice that occurs across the country and aims to track down, critically appraise, and incorporate evidence into individual clinical practice.<sup>1</sup> Arguing that patients are at risk of receiving care that is at best ineffectual and at worst harmful, evidence-based medicine seeks to shift the spectrum of ignorance towards a health service based on scientifically-based evidence at every level while health economics (HE) ensures we obtain value from our limited resources.

The EBM/HE industrial complex now employs a vast array of medical researchers armed with government grants and contracts seeking solutions to largely intractable problems — resources that might otherwise be used in direct health care. Every month there seems to be new spin-off — the NHS Centre for Reviews and Dissemination, *Effective Health Care* bulletins, *Bandolier*, the UK Cochrane Centre, the UK Clearing House on Health Outcomes, the Centre for Evidence Based Medicine, MEReC, NICE, CHI ... Using its ultimate instrument — economic analysis alongside the randomised controlled trial — the burgeoning industry seeks to discover the essential truth without us so that our interventions can be directed by explicit guidelines derived from rigorous enquiry.

Of course, GPs have always known that EBM consists of stories for children and that health economists remain entrapped within an academic paradigm divorced from the contingencies of the real world of health care delivery.<sup>2</sup> Not that clinical trials and or economic frameworks can't be illuminating — it's just the self-opinionated manner in which the parents tell us the stories as we

struggle against the directives of uncertainty.

But there is a new danger as the EBM/HE movement rapidly gathers pace. Hiding behind a cunning smokescreen of antagonism,<sup>3,4</sup> I have uncovered a sensational liaison revolving around a York–Oxford axis. Bernard Shaw's aphorism that all professionals are a conspiracy against the laity may be in urgent need of updating. It seems that health economists and medical scientists have been forming a conspiracy against those of us who labour against the complex non-linearity of the health care environment. What are the motives for this unholy alliance?

Until recently the EBM/HE complex continued to expand effortlessly, feeding on its own importance as a self-appointed panacea for all the problems in health. Proceeding as if the nature of the social world allowed rational solutions to be found in health it produces millions of research papers a year that, apart from a small handful, inform no-one except academic accreditation exercises. Procedurally rigorous and value free, the two empires have proceeded to emulate the physical sciences in their attempts to compress reality into an increasingly esoteric set of linear equations. Any derisory problems that do not fit the disciplinary paradigm or are difficult to quantify are readily discredited or simply ignored. As a result, attention can be diverted from the true nature of the social context of ill health<sup>5</sup> which produces and perpetuates the very problems the access seeks to address. But there was trouble on the horizon — things were not going accordingly to plan!

For some reason, GPs were not following evidence-based guidelines.<sup>6</sup> It appeared that practitioners were not being duped by frameworks that sought to compress the real world into an array of inferential statistics and where patients were seen as confounding variables in an otherwise perfect study design. But there was worse to come. National household surveys were beginning to show that, despite pouring billions into the medical research machine, people felt that their health was actually getting worse<sup>7</sup> and reports were suggesting that over the next decade we were all going to become more miserable.<sup>8</sup> Where was the E for EBM?

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The world of health economics, too, was looking decidedly shaky. Although still managing to overlook the fact that no-one was actually taking any notice of economic evaluations,<sup>9</sup> *Homoeconomicus* was not behaving as theory directed. In the evolving Health Service notions of scarcity and sacrifice, the bedrock of health economics, were being eroded by an emphasis on trust and partnership. Clearly, urgent action was called for.

The axis's strategy was to be brilliant in its simplicity. If patients could be duped into believing that they really needed the outpouring of the modern medical machine with all its trappings, but there was not enough to go around, then the technical framework of effectiveness and cost-effectiveness would be welcomed as a true salvation and the paradigm would remain secure. Forget about 'making choices' or 'setting priorities' — an all-out assault on the lexicon was to be the central tenet of the plan. Rationing — 'our inevitable fate'; 'condemning, shocking, scandalising.' Something was to be taken away and there would be those who would lose out. Patients defying the EBM/HE imperative would actually be at risk of facing the fact that life did not last forever!

The extent of the conspiracy can only be guessed at but the portents are not good — the power of the axis is everywhere. Frank Dobson fudged the Viagra decision which was made on the basis of common sense and old-fashioned pragmatism. Without a randomised controlled trial in sight, his career came to an abrupt end. Significant to note that his successor's first speech outlined a new vision for the NHS, acknowledging for the first time the need for rationing directed by evidence and cost-effectiveness.

These are dangerous times. Trust no one; eschew guidelines; reject meta-analysis; circumscribe clinical governance. As always, in the lowland swamps of primary care, GPs must proceed with caution.

**David Kernick**

**The Drama of Everyday Life****Karl E Scheibe**Harvard University Press, 2000  
HB, 296pp, £15.50 (0 67400231 8)

Ninety-nine years after Freud wrote his landmark volume *The Psychopathology of Everyday Life*, a millennial update has hit the shelves. Karl Scheibe's *The Drama of Everyday Life* consciously echoes the earlier title: like Freud at the start of the 20th century, Scheibe seeks to describe a 'quotidian psychology'. He hopes to explain, for example, why holidays involve such 'considerable expense and pain', why politicians should behave so stupidly, and why boredom might be 'the central motivational issue of our time'.

Scheibe bravely tackles these issues with minimal recourse to what he disparages as the 'scorekeeping' of 'reliable empirical compilations'. Instead, he prefers to evoke an 'immediate resonance' akin to that of poetry or music; to convince the reader by connecting with the 'known but inchoate and unarticulated experience of people'. He isn't content, in other words, merely to juggle his argument: he will do so while dancing a samba and singing the words of his favourite Brazilian songwriter, Chico Buarque de Hollanda: 'Today I have composed a samba right up front, really saying what I think'.

Sadly, the showmanship of his method ('We dramatise. All of us. Every day.') rather detracts from his point — which is, initially at least, intriguing. Asking why psychology should have failed to offer convincing accounts of our everyday lives, Scheibe reasons that this may be because of its dependence on an inappropriate homeostatic paradigm.

For too long, he argues, we've believed that Yin has to balance Yang, the four humours to be in equilibrium, and the Id to wrestle the superego: with the goal always a kind of 'utter quiescence'. Physiological paradigms of balanced excitation and inhibition might be relevant to the thyroid or the adrenal, but not to the soul.

It's hard to disagree: we'd all like to be more than the sum of our glands and everybody knows that 'quiescence' is aversively dull, forced isolation, a torment. Scheibe compares humans to sharks, who must swim in order to breathe: 'human beings must be in play, or in the play ... in order to retain their psychological vitality'.

Oscar Wilde made the same point with a different carnivore: 'Illicit sex was like feasting with panthers. The danger was half the excitement.' Psychology, therefore, 'must view life as drama and not try to explain away drama'.

This core thesis is neatly provocative, but Scheibe's conceptual samba becomes increasingly wobbly as the chapters (on

eating, sex, dancing, gambling, teaching and giving gifts) progress. His method takes much of the blame for this. Narrative often captures greater truth than cold empiricism, but convincing qualitative values are a long way from Scheibe's slack assertion that Joan of Arc became a martyred saint because of her 'aversion to boredom'. Particularly when this view seems to be based on his interpretation of the movie with Jean Seberg.

Scheibe neatly defines thrill as 'the willing entry into danger with a high probability of recovery', but such aphorisms don't do justice to the savagery and nihilism of war. Rwanda and Bosnia didn't happen because 'peace is too boring'.

It gets worse. Scheibe argues that clothes and cosmetics are agents of empowerment for women (men don't shop, he says, because of a 'restriction of their dramatic range in society'). He bizarrely conflates women achieving the vote in 1919 with the first Miss America Pageant in 1921, concluding that this was a sign of women's opportunity to diversify their roles in society. 'The same forces that kept women from making up their faces also kept them from escaping the domains of church, children and kitchen.' More lippy, girls!

The blundering assertions continue in a chapter about schizophrenia. Scheibe reckons that this severe mental illness is merely a dramatic concept that 'has no more ontological status than "unicorn"'. He recalls with fondness the 'ground troops' of his research team entering crowded mental hospitals in the 1960s, only to find that the numbers of people with schizophrenia were decreasing. 'Heavy artillery,' he says, 'had already done considerable damage to the structures they were entering ... the field generals had already lost heart.'

Sadly, his understanding of psychosis has remained stuck in this antipsychiatry time warp. He ignores, or is unaware of, two decades of brain imaging and genetic research that clearly delineate the core pathology of schizophrenia. The incidence of the disease may be declining, but this isn't because of changes in diagnostic fashion, and it's certainly not because those once considered schizophrenic are now labelled as suffering from PTSD, anorexia nervosa or multiple personality disorder. Such ill-informed conjecture reflects poorly on an academic psychologist, and undermines the validity of interesting points he makes elsewhere.

Scheibe's argument about the inappropriate dominance of the homeostatic paradigm is a good one, but he woefully overstates his case. A rhetorical scope that ranges from a child playing peek-a-boo to Nero dispatching unappreciative spectators at the Coliseum might be convincingly inclusive in some hands, but appears trivially eclectic here. Quoting 'a psychologist who works for the Department of Mental Health', or

recalling watching 'weddings in my father's church' as a child, are flimsy foundations for such an extensive thesis.

Scheibe approvingly quotes Erving Goffman in Chapter 2: 'All the world is not, of course, a stage, but the crucial ways in which it isn't are not easy to specify'. Unfortunately, Scheibe doesn't seem to have got this message: though his theatrical argument might look good from the front, there's not much to support it backstage.

*Michael Smith*

### **The Ethics of Health Care Rationing** **John Butler**

Cassell, 1999  
PB, 248pp, £16.99, 0 30470582 9

The NHS was created with a promise that it would provide comprehensive, high quality health care available on the basis of need rather than ability to pay. In his introduction, however, Butler declares these aims to be fundamentally incompatible and that rationing of care is a necessary reality. It is hard to imagine a situation where the health service is not cash limited, implying that the right to health care whatever the cost will be constrained by the need for rationing. This book is concerned with the attempt to place the structures, processes, and outcomes involved in an ethical framework and concludes with 'Stories from the coal face' — personal accounts by health care workers who have struggled to deal with the issues raised by rationing in their everyday work.

Butler suggests that, in the past, the governing principles of rationing appear to have been denial, dilution, and delay, and in turn rejects over-reliance on newer techniques, such as QALYS. Discussion of these processes suggests that most are inadequate and often represent crude reductionism incompatible with the individual experience of illness. Fortunately, he also notes that little has been written recently on the subject of rationing that did not explore the moral dilemmas that the process engenders.

How then should conflicts of competing demands for resources be decided and is it possible to identify a fair and ethical basis for making these judgements? Butler rejects both moral nihilism and absolutism which too often become fundamentalist dogma inappropriate for complicated problems, and his favoured approach appears to be the moral naturalism that many of the stories describe. Intuitively this seems correct, encompassing the familiar ethical values of utility and justice which, historically, have directed resources to those considered to be in greatest need. Many may view this approach with suspicion, seeing it as no more than old-fashioned medical paternalism, and though discussion takes place on how best to give patients an effective voice in the rationing debate it

seems a glaring omission that the stories from the 'sharp end' did not include the testimony of a patient.

Despite this caveat the strength of these stories lies in their familiar and deeply reflective nature and illustrate the authors' contention that consideration of ethical issues is required at every stage in the rationing process.

And, if all this seems a touch dry, Butler is not wholly devoid of a sense of humour. He prefaces debate on rationing with an advertisement from that other key influence on healthcare workers, namely the back street servicer of motor vehicles ...

'We provide three kinds of service — cheap, quick, and reliable. You can have any two, but you can't have all three. If it's cheap and quick it won't be reliable. If it's cheap and reliable, it won't be quick. And if it's quick and reliable, it won't be cheap.'

The NHS Executive and government ministers should take note.

*Niall Cameron*

**WHO Guide to Mental Health in Primary Care**  
**WHO Collaborating Centre for Mental Health Research and Training**  
Royal Society of Medicine Press,  
May 2000  
PB, 185pp, £12.95, 1 85315451 2

This book is a little cracker. Into fewer than 200 pages the authors have packed concise, well written accounts of a comprehensive range of the mental health problems that I encounter in my practice. The text of the book, supplemented by a large range of patient information leaflets, has also been compiled on a pair of floppy disks inside the back cover.

The style is ideal for a busy GP. Each topic is covered in short, two-to-six-page chapters. Information is presented in bulleted lists using simple unambiguous language. I could read through each chapter in minutes.

Another strength is the range of voluntary support organisations cited. Relevant organisations are listed at the end of each chapter, and a full list appears in a separate section at the end of the book. This list will date rapidly however; voluntary organisations often have a volatile existence. It therefore needs to be backed up by an on-line reference.

Short summaries of the 'six disorders most common in primary care' are printed on easy-to-copy sheets at the back of the book, using an interactive style that the authors hope might be emulated in a consultation. I haven't yet tried this. I suspect that fitting them into a ten-minute consultation might

present problems.

The list of references is extensive, and many are helpfully commented on. These included systematic reviews where available, and a useful range of grey literature, such as government papers.

I wonder how they selected these references. I also wonder how they managed to get the endorsement of the 11 organisations listed on the front cover.

There were hints of a highly sophisticated process used to write it. The topics were selected with reference to the GP morbidity survey. The text was informed by workshops involving the main endorsers. The book's impact on practitioners was assessed in a trial in the West Country. The story of the book's development would make interesting reading. It would also make important reading for those who like to appraise their evidence for themselves.

After such an involved process, I might well have expected to find some incoherence in style. But this hasn't happened. The book has immediacy, relevance, and cohesion. It is a credit to its editor.

Those who wish to sample before they buy can go to <http://www.rsm.ac.uk/pub/bkwho.htm> for a free PDF copy.

*Joe Neary*

## Bridging the gap between theory and reality — A call for vernacular health economics

We are currently going through an evolutionary phase in testing interventions to address the questions 'Can it work? Does it work? Is it worth it?' Health economists have a crucial input into the 'Is it worth it?' element and will exert an increasing influence on the decisions GPs make. Unfortunately, they remain trapped within a theoretical paradigm which is not keeping pace with the pragmatic demands of primary care practitioners, researchers, and managers.

Evolving from mainstream economics in the late 60s, the future direction of the new discipline was succinctly predicted by the thoughts of Alan Williams, one of health economics' founding fathers: 'Until we are able to explain to medics and managers in rather simple terms what we are at, we had better keep such studies strictly within the family'. The canonisation of health economic theory was set to develop, isolated from contamination with the contingencies of the real world as health economists were left to work largely undisturbed in their ivory towers. From this cloistered environment health care was to be viewed as a technical act accompanied by explicit decisions based on an elevation of the mathematical: an approach that was to be invariably inaccessible to end users and which attempted to compress reality into a disciplinary framework rather than the more logical converse.

Berwick has suggested that to improve health care we need better systems of work, where the trick is to attend more to the interactions than the elements. Unfortunately, a translation between the rival paradigms of medicine and health economics is impeded by different methodologies and cognitive values. Central to economic analysis is the concept of value, reflected in the notions of scarcity and sacrifice. However, this model of '*Homoeconomicus*' excludes the complex motives of patients and health care

practitioners and the environment in which they operate. Health economists remain obsessed with maximisation in a simple rational system, whereas the world of commissioners and practitioners is complex and often composed of multiple irrational social constructs.

As the spotlight moves away from evidence-based medicine to health service research and development with its focus on efficient use of limited resources, health economics can offer critical insights and techniques to facilitate the delivery of efficient and equitable health care. But there is a danger that organisations such as NICE, charged with seeking simple solutions to inherently complex problems, will be seduced by the easy answers that health economists supply. Just as there is a need to refocus the research effort and methodologies to reflect the practical realities of patient care and service delivery, there is a call for a new health economics.

Vernacular health economics rejects esoteric theoretical discourse and inaccessible mathematical formulation and moves on to accommodate the contingencies of the real world. It emphasises the importance of pragmatism; living with the uncertain; being vaguely right rather than precisely wrong; recognising that, in the complex environment of health care, analytical and predictive power comes from standing back and taking a broader view. A recognition that most commissioners of health care don't want to change the world but seek to make marginal change on the basis of historical precedent and limited room for manoeuvre.

Bridging the gap between theory and reality is the challenge of the next decade. Just as studies of efficacy are being replaced by those of effectiveness, the 'Is it worth it?' question must be translated into the practical realities of health service delivery.

**David Kernick**

## iain bamforth

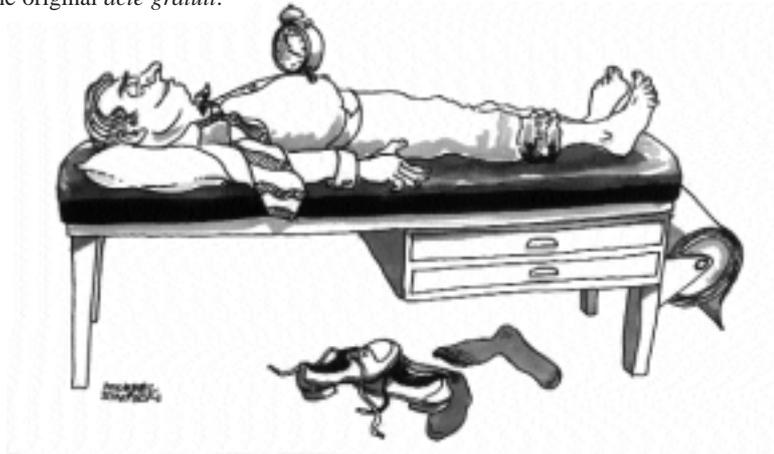
### Sleeping on the Job

My father-in-law is a German journalist who still writes well into his retirement. He may owe this to a remarkable ability: he flops down on his couch in the afternoon, closes his eyes for fifteen minutes, and then gets up refreshed and alert, ready to follow the rare trailing wind of ideas. He has done this all through his professional life, and swears by it. He calls it a *Nickerchen*; the French say *méridienne* (title of Van Gogh's great painting of 1889 of two peasants snoozing in the lee of the haystack); in English we take a nap, or the curious forty winks. *Siesta* is a universal word (Latin: *sexta* — sixth hour for sundial users) but maybe a little too exotic-sounding for the British. I've tried to acquire this rather clandestine ability myself, but my body — or perhaps my mind — doesn't work like my father-in-law's. I'm not a *Homo siestus*, except perhaps on holiday in Provence when the sun drums on the shutters, the cicadas garble the Morse code manuals all day long, and only geckos are fleet of foot. Yet according to recent sophrological studies, 80% of humans verge towards sleep after eating at midday. It doesn't depend on alcohol or calorific intake, and taking a nap has no effect on the archaeology of nocturnal slow wave sleep. But a good siesta has to obey body rhythms: it means napping for no longer than 20 minutes.

The nap has a long pedigree. Hippocrates thought that a sleep after eating properly moistened and sent the food to all parts of the body. The best known classical siesta-taker was the cynic philosopher Diogenes, who is remembered by everyone because he lived in a tub. He was famously rude to Alexander the Great in Corinth because the upstart dared disturb him during his tub-nap. 'Is there anything I can do for you?' asked Alexander. 'Get out of the sun' suggested Diogenes. Homer mentions in the *Iliad* that Nestor was almost as touchy as Diogenes about not being disturbed in the afternoon, whatever happened to the Greek fleet. In China, the right to nap is enshrined in the Constitution. Peru once had to quell an uprising because its government foolishly thought to ban siestas. Europe's class struggle extended even to sleep. Paul Lafargue, Marx's brother-in-law, wrote a tract called *Droit à la Paresse*, demanding that the proletariat ought to work at most three hours a day with the rest of the time set aside for the pursuit of enjoyable things, including siestas. Nietzsche, though no lover of the proletariat, agreed: anyone who didn't have two-thirds of the day to himself was a slave.

Compare that attitude to the time-and-motion studies (read 'auditing') of a certain American called F W Taylor, which swept across a Europe producing armaments as hard as it could in the First World War. Having discovered how to manipulate matter, the second industrial revolution put its mind to the management of humans. Fat chance of a siesta when a foreman's job was to drum production line rhythms into his workers. It was the machine that counted, and the machine never slept. Now, as we enter the third industrial revolution, the siesta's slightly furtive moment of repose has been rediscovered — by Americans. Americans are slaves to the idea of tomorrow, and rather gnostic about today: they call this the work ethic. Yet a World Nap Association (WNO) now exists, with its own web site. It is apologetic about what it promotes, pointing out that, for most Americans, napping still bears the taint of Sloth, one of the seven deadly sins. *Roget's Thesaurus* associates the word with 'indolence, inactivity, loafing, procrastination, lethargy, slouching, vegetating', none of them exactly glowing recommendations. The WNO claims this is a legacy from America's colonial past, but I'm not so sure. Look at the way American creative management thinks having a pause in the middle of the day is a new idea. Gould Evans architects' office in Kansas City has just installed a napping loft for its employees to combat the performance dip between 2.00 and 4.00 pm. They've got it all wrong, though. If you impose a siesta on people, you destroy the reason for having one at all.

So next time you feel an urge to lie down on the cool black leather for a few minutes before the afternoon surgery, just do it. Napping, as Diogenes but none of the existentialists realised, is the original *acte gratuit*.



### Useful suggestions ...

- All practices need to have a clear and publicised anti-discrimination and confidentiality policy; this has been shown to increase the number of people with HIV willing to access primary care.
- Local Medical Committees should state their policy on HIV management and seek clear guidance for local GPs about how to deal with questions in reports to third parties.
- Sexual health should be a core area for both PCGs and Health Improvement Programmes (HIMPs)
- Increased training — particularly in relation to sexual health and the management of drug users — for all members of the primary health care team and other members of PCGs.

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## Redefining the Role of Primary Care in HIV

Sixty GPs and others working in primary care gathered at the RCGP for the 7th National Conference of the RCGP HIV Working Party, which was held at the end of March. Their aim was to re-examine the place of primary care in the current age of HIV infection and treatment.

The Chair of the HIV Working Party, Chris Ford, began with an overview, explaining how HIV infection and AIDS had changed over the past 19 years. Increased survival rates following the introduction of combination anti-HIV therapy have led to a greatly improved outlook for those living with HIV infection in the UK, with longer survival and significantly less hospitalisation. However, the prevalence of HIV infection is increasing steadily<sup>1</sup> despite the reduction in the number of deaths. It is now treated as a chronic relapsing condition — a situation which primary care workers are well used to managing.

The three phases of HIV infection<sup>1</sup> began with the 'discovery' phase in the early 1980s, when the first cases were being recognised, antibody testing for HIV became available, and the main routes of infection became clear. There was little impact in primary care; management was developed by specialists with only some care, particularly terminal, managed by the primary care team. The second phase, from 1988 to 1995, was an era of increased numbers — mainly of men who had sex with men, but also of injecting drug users, particularly in Scotland. There was developing knowledge in primary care and during this time the RCGP HIV Working Party was established in response to a Social Services Committee, which portrayed GPs as ignorant about AIDS.<sup>2</sup> The Working Party wanted to show that GPs were willing and competent to care for people with HIV infection. The third phase has, since 1996, been characterised by a decrease in AIDS-defining illness and a sharp decline in mortality in the UK, but it has also seen increased prevalence and increasing costs of treatment and care. Although new HIV infection continues there are still many undiagnosed infections and also many infections diagnosed late in the clinical illness. People continue to put themselves at risk through unsafe sexual practices and needle-sharing. Primary care is also changing during this time, moving away from being GP-centred and instead working in teams and taking on an increasing role in commissioning.

There has been some movement towards increasing the level of HIV care in primary care, helped by these changes. However, there is still considerable anxiety with regard to confidentiality, training, and keeping up to date.

Although survival has increased there is still no cure for HIV infection and the current medication regimes are demanding and can be associated with significant side-effects — there is no room for complacency. The role of prevention must never be forgotten. HIV testing has its place in prevention and we must think about the advantages of facilitating HIV testing within primary care, especially as we have such a poor record in the UK with late diagnoses.

Dr Valerie Billingham from the Department of Health described an updated and revised HIV/AIDS strategy for England, as care needs for people living with HIV have evolved. Her presentation provoked lively debate about the importance of the role of primary care being acknowledged in the HIV/AIDS National Strategy.

Dr Nick Theobald (Vice Chair of the Working Party) reviewed current issues in the management of HIV infection, including issues of workload and costs, the latest BHIVA Treatment Guidelines, and concerns over anti-retroviral resistance. He described common side-effects of combination therapy and the importance of good adherence to drug regimes.

Dr Sara Madge discussed problems with HIV prevention and detection. Many people in the UK present later than in most of the rest of Europe (apart from Ukraine). In 1996, 87% of UK pregnant women with HIV still remained undetected and detection rates are especially low in African communities. Dr Madge attributed poor UK performance to a lack of integration of sexual health services, low uptake of HIV testing in primary care, and the concerns of medical record disclosure to third parties (for example life insurers). Training around these issues needs strengthening at both undergraduate and postgraduate levels. But there were some brighter corners — HIV antenatal testing had dramatically improved and uptake is now 80% to 90% in many London hospitals. We needed to continue needle exchanges and there was some evidence, via the anonymous testing programme, that some improvement in detection had been achieved.

Dr Surinder Singh discussed confidentiality, insurance, and access: major issues for the HIV Working Party. 'There are doubts as to whether this system [of doctors giving insurance companies clinical information] continues to be in the best interest of patients.'<sup>3</sup> BMA advice, from 1988, stated that 'Doctors are advised to avoid invitations by insurance companies to speculate about the patient lifestyles. Doctors may respond to these questions by referring the insurers back to the patient.'

## neville goodman

### Reasons to be cheerful, one two three ...

I know I'm a little late, but I must mark Ian Dury's passing in March this year. He contracted polio as a child, which left him markedly one-sided. He could easily have written 'Reasons to be tearful ...', but though he was one-sided, with a withered left arm and leg, he thankfully had no chip on either shoulder. He was a cripple. He didn't worry that he was a cripple; he just admitted it and got on and made the best of it. And his best was pretty good. He became famous as a pop star, a punk rocker whose many gems included *Sex and drugs and rock 'n' roll* and *Hit me with your rhythm stick*. When his pop star faded, he did other things.

There's something sad about pop stars dying of mundane diseases. They should die young, of drug overdoses, or wrapped around lampposts in fast cars. Seeing them die of the mundane is a powerful reminder of one's own mortality. The first time that happened to me was when Frank Zappa died. How could the man who recorded *Weasels ripped my flesh*, the cover of which featured a leering man pulling a weasel down his cheek much as he might have wielded an electric razor, die of prostate cancer? Ian Dury died of liver secondaries from cancer of the colon. He did that well, too. He didn't make a fuss, carried on performing, and to the end reckoned he'd had 58 pretty good years — cancer and withered limbs notwithstanding.

We now have the disability discrimination act to take account of, as well as the sex discrimination and racial discrimination acts. And so we should, but there is a movement afoot in which it is politically incorrect to assert that the disabled are no less able than the rest. This is physiological and anatomical nonsense. Instead of using disabilities for ego-boosting and attention-getting purposes the disabled would be better withdrawing from activities they can't effectively do and concentrate on those which they can.

Before appalled readers send me hate e-mail, I should point out that the last half of the previous paragraph is taken directly from a letter to the *The Guardian* (11 November, 1999). The writer is severely deaf and was objecting to the righteous indignation provoked when a deaf man was barred from sitting on a jury. The letter writer had concentrated on what he could do, commenting, 'I've done this, so can others'.

Ian Dury wasn't differently abled; he was able, and he did.

Nev.W.Goodman@bris.ac.uk

In 1991, the RCGP stated that 'GPs, in response to questions from insurance companies should give medical facts only and not answer lifestyle questions'. The Association of British Insurers issued their own guidance in 1994: 'Insurers should not ask applicants whether they have been tested for HIV, but only whether they are HIV positive'.

The Working Party still has to consider how GPs should manage lifestyle questions on PMA reports and how negative HIV tests affect insurance applications. It is unclear where GPs should seek guidance on these issues, while safeguarding the doctor-patient relationship. Research shows that the majority of GPs complete between one and 10 PMA reports per month and that 48% were influenced in their reporting by life insurance considerations. Thirty-eight per cent of GPs still felt obliged to supply lifestyle information and only 8% of GPs felt adequately informed as to how insurance companies use this information.<sup>4</sup> Perhaps the pragmatic way forward was for patients to be shown the PMA questionnaire at the time of consent and for GPs to show all completed forms to patients before sending them. Authoritative advice is needed for the profession. Dr Singh quoted Dr J Harvard, Barrister and Secretary of the BMA, who said in 1989 that 'it would be difficult to name a democracy in the Western World that pays less respect to confidential medical information than the United Kingdom'.

Conference work groups discussed issues of care, prevention and detection, and good management. The main points that emerged were the need for improved communication, particularly between primary and secondary care, and the need for normalisation of HIV testing. HIV testing should increase in settings other than GU clinics.

The conference concluded with the adoption of a consensus statement: 'Patient care and the relationship between patient and doctor is adversely affected by third person disclosure (in areas of life insurance and employment) of information held in medical records. Purely because the applicant's signature is obtained on the application form this does not constitute informed consent and full awareness of its implications. Delegates welcome the willingness of the GMC to reassess its position on confidentiality in this context and look forward to the publication of guidance, which offers affective protection to patients and offers clear advice to doctors in their relations with commercially motivated third parties.'

Chris Ford  
Nick Theobald

## our contributors

**Iain Bamforth** was a GP in Strasbourg, and still begins each day with a brisk swim in the Rhine. His offering for this year's Christmas *Journal* remains a closely guarded secret ...

And talking of swimwear, we salute **Niall Cameron** editor of the Lifestyle section of *hoolet*, the journal of RCGP Scotland. Niall combines enthusiasm for orchids and tight Milanese underwear with a T1ree genome, one of Nature's more painful dichotomies. He's a GP in Govan, Glasgow

**Rosie Donovan** is a Scottish photographer who has lived in Canada since 1972. She studied photography at Beal Art School and the University of Western Ontario. She is a passionate observer of people, capturing the essence of her subjects, meticulously posing them to reflect their personalities, lifestyles and interests. She works exclusively in black and white, using available light. See <http://www.rosiedonovan.com>

**Chris Ford** chairs the RCGP HIV/AIDS Working Group. She practises at the Lonsdale Medical Centre in north-west London

**Neville Goodman** is a consultant anaesthetist in Southmead Hospital in Bristol

**Peter Hawker** is a consultant gastro-enterologist in the Midlands. He is also Chairman of the Central Consultants' Committee of the BMA

**David Kernick** is a GP in Exeter

**Angela Lennox** is a GP in Leicester and is Director at the Centre for Studies in Community Health Care, Division of Medical Education, Leicester-Warwick Medical School

**Jane Macnaughton** is Director of the Centre for Arts and Humanities in Health and Medicine (CAHHM), at Durham. Her latest book (with Robin Downie), *Clinical Judgement* (Radcliffe) will be reviewed in a forthcoming issue of the *Journal*

**Joe Neary** is Chairman of the RCGP's Clinical and Special Projects Committee and a member of RCGP Council for East Anglia

Meanwhile, modern telecommunication allows the *Journal* to contact potential reviewers in the most unlikely locations.

**Michael Smith**, for example, was browsing in Harvey Nicks, Kensington... "You'll be in the women's lingerie section, Michael," said your editor, and indeed he was. At other times Dr Smith is a psychiatrist, unsurprisingly

**Nick Theobald** is Vice Chair, RCGP HIV/AIDS Working Group, and practises at St Stephen's Clinic in Chelsea and Westminster Hospital, west London

**James Willis** is a GP in Hampshire

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

## james willis

### Unlikely incontinence

I concentrate my attention on making careful notes on the computer, because I can't, for the moment, think exactly what to say. It isn't going to help him very much to say his problem is very unlikely.

"So it's four, five ... mmm ... nearly SIX weeks since your prostatectomy...?"

"Right, six weeks."

"And are you wet EVERY night? Or just a ...?" "I see, it comes in bouts. Oops — sorry, in my next life I'm coming back as a good typist. That's it, 'bouts'."

"And apart from that the operation went very well?"

"Yes, brilliant. Oh well, of course they are all very busy. Well, very nice to hear you say so. Absolutely, praise does a thousand times more good than criticism. Yes, lovely man as well. Very good surgeon. Very up to date."

"Right, so at about four in the morning, each of the last four mornings, you've been soaked right through ..."

So there we are.

Mmmm.

"Well, I think the best thing would be if I wrote to the specialist and told him what has happened ...". Pick up the tape recorder and slip in a tape, lean back in the tilting chair. "Letter to Mr X, Mr Y is doing very well six weeks after his uncomplicated TURP with as you know, benign histology. However ... etc, etc, I would be very grateful for your advice ... yours sincerely."

"Well. There we are, that's that. That will be typed straight away and we'll see what he has to say."

"Do now? Oh right. Well, what about getting some padding from the chemist? There are tablets that I could give you but you'd have to take them all the time and they might actually make you less likely to get better by yourself."

"Yes, I agree, it would be better to see what happens for a few more days, and we can get a urine sample checked and that sort of thing ..."

"No, I'm afraid we can't prescribe the pads. It's bad, isn't it, but there we are, we spend all the money on computers these days ... Ha Ha. Let me know and I'll ask the district nurse to call if you have any problems."

He may have a UTI, of course. But I've got a nasty feeling that he is one of the small proportion of TURP patients who is going to have postoperative incontinence and there is not very much that anybody is going to be able to do about it.

And I can't help musing over the contrast between the two views of this situation. There is the view of the surgeon, who is indeed, absolutely first-class, who accepts that a small proportion of patients (does the figure really matter, even if I looked it up?) will become incontinent, and that by the norms he is actually doing rather well, and the view of the patient, for whom the figure is 100%; he's got it and that is that. The fact that it was very unlikely that he has got it doesn't make the slightest difference and is completely irrelevant to his situation. To the specialist, to the management, to the health economists, to the GMC, to the press, on the other hand, it is everything.

There is a lot of this sort of thing in medicine: the two views that can't be reconciled. The fact that something is unlikely doesn't matter to us at all when we actually have to deal with it. I looked after a patient with acromegaly for 15 years — saw her hundreds of times. The fact that she was very unlikely didn't make her only partly there. In fact, having acromegaly, she was rather more there than most people.

Yes, we see a lot of this sort of thing. We call it the mystery of general practice. And the world simply doesn't understand.