The British Journal of General Practice

## Viewpoint

**Breaking the Silence**

The fear of dying of AIDS is no longer a concern for us. The epidemic in Edinburgh in the 1980s was controlled with intensive health promotion before anti-AIDS drugs and there has been little 'seepage' into the heterosexual population. Even gays are becoming more relaxed about their sexual behaviour: one reads of celebratory 'seroconversion parties' as high-risk behaviour is back in fashion. The antiretroviral drugs, kicking in at an annual cost of £8000–£10 000 per person, along with expensive viral assays, have worked wonders … so far.

So that's one more disease conquered by the miracles of modern science? Well, not quite. The July Durban UNAIDS conference, entitled 'Breaking the Silence', heard differently.

Shock waves went around the world when the President of Botswana said his country faced extinction. One in three of his population is infected, as is half the adult population of some cities in Zambia, Malawi and Botswana. There are 16 000 new cases worldwide every day, 8000 of these in Africa. We are even becoming blasé to the grim statistics: HIV is now the single largest infectious killer and the fourth leading cause of death in the world. AIDS will lower life expectancy by 25 years in some countries: death, sickness, and numbers of orphans will continue to rise well into the next century.

What is driving the disease and why is it so bad in Africa? Many believe that other continents, such as the Indian subcontinent, risk similar rates unless they take action now. The epidemic in poor countries is almost totally heterosexual. In a recent *Guardian* article Maggie O'Kane described some of the sexual cultural practices in Malawi that are driving the spread of the virus. Young girls are prepared for marriage by taking them out into the bush for sex with a single man elected by village elders, 'a man of experience'. Practices like this, which allow an entire village of 14-year-olds to be initiated by one man, may explain why HIV ratios in young women are now three times that of young men. But why do girls (and their mothers) allow this? Why is behaviour so slow to change? Lack of education is one factor.

Only if girls and women can read and write do they have any chance of protecting themselves from physical and sexual exploitation. Without education they are powerless to negotiate safer sex. Even then it is difficult in many macho cultures. In Zambia, one-third of school-age children — mainly girls — are not enrolled in schools, and when they are they face untrained teachers, sit on the floor, do not have books, paper or pencils, and have to pay expensive fees for the privilege. Twenty years ago, education was free in Zambia.

AIDS is a disease of poverty and social injustice. It is in poor countries with declining health and educational services that the virus has gained the biggest foothold. Countries where public health agendas have been slashed, where tuberculosis and STD programmes have been cut, where fees are charged for health care, and where millions dying in distress and pain because they cannot afford simple pain relief or cheap antibiotics.

Forget the antiretroviral drugs (for the moment). Despite the clamour at the Durban UNAIDS conference for easier, cheaper access to these drugs, they will not solve Africa's AIDS problem. Few countries have the laboratory infrastructure on which to prescribe them safely, even if their cost fell dramatically. What is needed now is low cost essential drugs, drugs to treat TB and STDs and other co-infections, and doctors and nurses to deliver basic health care. Plus a huge health promotion campaign backed from every level of government. Plus jobs, food, roads, and schools.

Can we in the West afford to ignore this epidemic in far-off places? Simple self-interest must tell us that we risk social upheaval in the south if we do. But I do not think we are morally immune to what is happening. We want to help but find it difficult to know how. Perhaps it is useful to remember that nine-tenths of all people living with HIV/AIDS are in countries which are becoming steadily poorer. The question we must ask ourselves is how we can contribute to halting the ever-widening gap between rich and poor.

**Dorothy Logie**

"Whether or not the strategy is the best one, I have no doubt that this government is committed to rebuilding a health service of which we can be proud.

So I feel a bit guilty about complaining but, like all commentators, I have a vested interest ..."

Harvey Marcovitch, on *NHS Plan* page 766

"It's a gift from the College to this world ..."

David Jewell, on the *Journal*, with apologies to Neil Young, page 775

## contents



# The Back Pages

news

**GP Registrar observers needed**

The College has a vacancy for a second GP Registrar observer on the RCGP Council. The role is about making sure that GPRs play a full role in their academic body and involves helping the College improve its service to them.

Responsibilities include attendance at five Council meetings a year and representing the interests of GPRs as a member of the JCPTGP which meets quarterly. Travel and subsistence expenses will be paid. The GPR observer serves on Council for two years.

If you are an associate of the College and are either in training for general practice or have completed vocational training after 31 March 2000, then you can write for a nomination form, available from the Returning Officer, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU; tel: 020 7581 3232 ext 246. The closing date for return of forms is **6 October 2000**.

Ballot papers will be sent to GPR Associate members of the College in October. The name of the successful candidate will be announced at the College's AGM on 17 November 2000.

**Annual St Paul Lecture**

Peter Homa, Chief Executive of the Commission for Health Improvement will be delivering the annual St Paul Health Care Lecture at the Royal Society of Medicine on 12 September.

The lecture will focus on the work of the Commission and how it will impact on clinicians.

Professor Mike Pringle, Chairman of RCGP Council, will also be in attendance to host a question and answer session and to give the College's perspective on the relationship between primary care and the Commission.

Attendance at the lecture is by invitation only. If you are interested in attending then please call 01737 787787 or e-mail **helen_king@stpaul.com**

## The Marshall Marinker Award for Excellence in General Practice

The 1999 Marshall Marinker Prize has been awarded to London-based GP Dr Trisha Greenhalgh, a general practitioner and senior lecturer in primary care. The award was made by Sir Donald Irvine, President of the General Medical Council and Chairman of the judging panel, and Professor Marshall Marinker, at a celebration dinner in April.

As in previous years, the winner will typically have been responsible for successful, influential and sustained innovation in one or more of such fields as practice and health service development, medical education, research, audit, professional development and health policy. With the advent of Primary Care Groups and the introduction of clinical governance, general practice is now politically empowered to respond to innovative and imaginative ways to the challenge of health service development, and the quality of care.

Dr Greenhalgh's projects have spanned a broad range of research, teaching and clinical practice and she is widely published in all areas. She has recently set up the world's first fully web-based MSc course in primary care, a programme which provides students from around the world with access to flexible, modular, interactive learning, based around the virtual small group seminar.

Dr Greenhalgh is renowned for her work in evidence-based healthcare, and in particular has been prominent in encouraging the integration of an 'evidence-based' approach to diagnosis and therapy with a narrative–interpretive perspective, aimed at improving the quality of the consultation. Her main clinical interest is diabetes and she is leading a multidisciplinary research team on a long-term project to explore and address barriers to optimum health outcomes in British Bangladeshi patients with diabetes.

In addition to the winner, the judges also awarded a Certificate of Merit to Dr Amanda Howe, a Sheffield based GP. Her recent projects include establishing and leading the community-based teaching curriculum at Sheffield, which continues to develop. She has also undertaken extensive research in the area of education and changing clinician behaviour and is widely published.

Nominations for the 2000 prize are now invited from Heads of University Departments of General Practice, Regional Advisors in General Practice or by Faculty Provosts of the RCGP. Candidates should be aged 45 or less on 31 December of this year and be working in the UK or the Republic of Ireland. The nominator's and candidate's forms should be completed and returned together to: External Affairs Department, Merck Sharp & Dohme, Hertford Road, Hoddesdon, Herts, EN11 9BU.

## Retired Members' Tea Party

Some 68 people from all over the UK attended the gathering held at Princes Gate in July, of whom 13 were founder members.

The delegates discussed their activities since retirement, which included working with St John's Ambulance and sick colleagues; care for patients at home with Alzheimer's disease; and revalidation. Dr George Pagdin reported the current activities of those retired members who were not able to attend the meeting.

The Honorary Secretary, Dr Maureen Baker gave a presentation on the topics of good medical practice, revalidation, the National Plan, and vocational training. Afterwards, Dr Baker took questions from the floor and the President, Sir Denis Pereira Gray and Head of Council, Mike Pringle took questions raised on the topic of revalidation.

Sarah Thewlis, General Manager, then gave presentation on the history of the Princes Gate building, and members were later invited to tour the building as well as take the opportunity to meet old friends. Afterwards, there was a video presentation from the College's archives featuring an interview between Past President Dr Alastair Donald and the Late Dr William Fulton, a founder member.

We have received suggestions that it would be useful if an event like this is held locally. Faculties might look into hosting a similar event at local level. If your faculty is interested in hosting a similar event, or if you have any ideas you wish to put forward, or would like to publish an article in the Faculty Newsletter, then please contact Mrs Mayuri Patel, Clerk to the Retired Doctors Working Group, RCGP, 14 Princes Gate, Hyde Park, London, SW7 1PU; fax 020 7589 3145; e-mail: mpatel@rcgp.org.uk

## Pesticides

The investigation, diagnosis, and reporting of suspected non-acute pesticide exposure cases is not made easy for the GP. Some practitioners, patients, and public interest groups are concerned that there may be significant underdiagnosis.

A system for the management of acute poisonings is well established, but there is little independent information on low-level exposure.

The Joint Working Party of the Royal College of Physicians and Royal College of Psychiatrists recommended that the patient's GP should be the initial focal point for treatment for the majority of sufferers from organophosphate-related disorders.

Although pesticides are approved only after examination of data packages, even regulators are concerned about the potential adverse impacts of pesticides on health. Scientific progress uncovers new issues, linking pesticides to cancers and reproductive and neurological disorders.

In the context of a putative primary care-led National Health Service, the evidence-base for pesticide-related illness will be formed at primary care level. How should GPs contribute?

To tackle these questions, a PGEA-accredited seminar for GPs on pesticides and health is being held on Wednesday 27 September, in London, organised by Pesticide Action Network UK, an independent non-profit organisation, in collaboration with Professor Andrew Watterson, Occupational and Environmental Health Research Group, University of Stirling; Dr Vyvyan Howard, a foetotoxicologist, University of Liverpool; Dr Sarah Myhill, a GP; and Dr Elizabeth Haworth, a Consultant in Communicable Disease Control for Buckinghamshire.

The aim of the seminar is to enable delegates to investigate, diagnose, and report pesticide exposure cases, both acute and low-level. Documented cases will be presented, and the medical and statutory responses analysed. Key groups of pesticides and their toxicology will be covered, and sources of information on toxicology, existing surveillance systems, and specialist resources described.

For full details on this and future events contact Pesticide Action Network UK, tel 020 7274 6611, or look on the web at: **www.pan-uk.org**, where you can gain access to our Information Updates and join Pesticides Action Network UK.

**Alison Craig**

**THE BLISTERS GUIDE TO NONSENSE***

WHEN STUCK IN A BORING MEETING, eg PCG, LMC, TRAINERS GROUP, GPC OR EVEN POSSIBLY COLLEGE COUNCIL OR WHEN READING A LESS THAN RIVETING JOURNAL OR ARTICLE – TAKE OUT YOUR BLISTERS CARD. WHENEVER SOMEONE SAYS, OR YOU READ, A WORD LISTED BELOW, CROSS IT OUT. WHEN YOU HAVE COMPLETED A LINE IN ANY DIRECTION, SHOUT BULLSHIT LOUDLY. THE EFFECT IS HIGHLY THERAPEUTIC

| | | | | | |
|---|---|---|---|---|---|
| SEAMLESS CARE | I WILL BE BRIEF | BEST PRACTICE | BLAIR | HOLISTIC | HUB AND SPOKE MODELS |
| THE NATIONAL PLAN | CHAIR, IF I MIGHT BE ALLOWED TO COMMENT AGAIN | GATEKEEPER ROLE | PROFESSIONALLY LED | ALTERNATIVE MEDICINE THERAPIES PRACTITIONERS | PRIVATE FINANCE INITIATIVE (PFI) |
| PRIMARY CARE LED NHS | PRIORITISATION | RESOURCE ALLOCATION | LEAGUE TABLES | CONTINUITY OF CARE | EVIDENCE BASED |
| IN THIS DISCUSSION NO-ONE HAS YET MENTIONED PATIENTS | CASCADE | FLEXIBLE WORKING | APPRAISAL | PARADIGM | META-ANALYSIS |
| THIS IS THE MOST SIGNIFICANT ISSUE FOR GENERAL PRACTICE FOR ..... YEARS | NEEDS LED USER SENSITIVE ENVIRONMENT | HARD/SOFT (eg CRITERIA) | NON-THREATENING | POSITION PAPER | PERFORMANCE RELATED |
| MULTI-DISCIPLINARY | MILBURN | PROTOCOLS | SKILL MIX | NURSE LED TRIAGE | CLINICAL GOVERNANCE |

* BULLSHIT

PHILIP EVANS

# The NHS Plan - *A plan for investment, A plan for*

Nobody doubts that the NHS needs to be improved. However discussion often ignores the fact that most patients receive excellent care most of the time. Where problems arise — dirty hospitals, long waits for surgery — they are usually owing to two chronic problems: underfunding and too few clinicians.

If this analysis is right, then the recognition of underfunding (and the provision of funds) and the poor capacity of the service are the key foundations for improvement. My initial disappointment stems, therefore, from the small planned increase in GP numbers. We are stretched now. We will reach our elastic limit well before we can deliver on the aspirations in this plan.

Like all governments, they cannot just offer the obvious solutions. A one-page document saying they would fund the service adequately and expand the workforce as rapidly as possible was all that was really required. However, they have also put together a patchwork of changes that will 'modernise' the NHS. Most of them are necessary and can be supported. Some are wrong — why victimise single-handed doctors?

Overall, its a curate's egg and we will need to identify and fight the bad parts. If it heralds a real long-term political will to correct the chronic underfunding of the service then we will probably look back on this plan as more good than bad.

***Mike Pringle***

It is now well accepted that in any health service you can only ever have any two of 'accessibility', 'quality', and 'affordability'. So which one is the government choosing to sacrifice in this fascinating document which confuses wishful thinking with policy? I know where I'd put my money. Where are they putting theirs?

***David Haslam***

This is a political document. That explains its strengths and its weaknesses. They are the strengths and weaknesses of this government. Substitute the word 'voter' for the word 'patient' throughout and it makes perfect sense.

It argues, intelligently and with transparent conviction, for the preservation of the founding principles of the NHS and for the continuation of its funding from general taxation. A thousand thanks for that. It is well informed and readers will find a large number of their current concerns — 'Delay seems designed in the system', 'Perverse incentives' — sympathetically articulated. And, with the exception of one word, 'incentivised', used twice, it is written clearly, in English. For that, again, much thanks.

Its weaknesses include the species of deceit they will call 'spin'. 'Ten thousand extra qualified nurses and 4780 more doctors working in the NHS since 1997'; I simply don't believe them. 'Services have to be tailor-made, not mass-produced'; fine words which mean, 'Doctors, therapists, and nurses will increasingly work to standard protocols.' 'Trust people on the front-line … the centre will only do what it needs to do', means still more reckless additions to the paraphernalia of untested regulatory agencies. 'Earned autonomy', at face value a very interesting idea, means 'green-light' organisations will get their Commission for Health Improvement checks a little less often than naughty 'red-light' organisations. The meaning is clear; this is a government that deserves its control-freak sobriquet. And also, sadly, its 'red-light' record as an 'incentiviser' of professionals.

This plan is not the most radical ever (what about Mrs Thatcher's attempted ethos change from service to business?) and it is certainly not radical enough. They earned the admiration of the world by freeing the Bank of England from political control; they have missed this opportunity to free the NHS as well.

***James Willis***

This is my 34th year in the NHS. I watched, with mounting despair, as it was strangled by the previous government using a poisonous combination of accident and design.

As I prepare to be put out to grass, my natural optimism demands that I salute this attempt to reverse two decades of decline. Whether or not the strategy is the best one, I have no doubt that this government is committed to rebuilding a health service of which we can be proud.

So I feel a bit guilty about complaining, but like all commentators I have a vested interest. Mine is the 25% of the population aged under 16 who scarcely exist so far as the NHS Plan is concerned. There are several mentions of the plight of 'looked after' children but little about sick children or newborns. 'An apple a day' at school is a neat gimmick but hardly the answer to our current alarming pandemics of paediatric obesity, lack of fitness, constipation, and behaviour problems.

Where are the bold plans to ensure all newborn babies have the best possible start? Where is the commitment to concentrating on childhood when preventing chronic adult disability? Where is the vision we saw in the Court report a quarter of a century ago in marrying primary and secondary care for children in a coherent way? Where is any mention at all of the need to have a child and adolescent mental health service that is more than token?

Nowhere I'm afraid; hardly surprising since the body which produced the document was singularly lacking in input from doctors who understand about these things.

We need a National Service Framework for children. Who knows if we will get it.

***Harvey Marcovitch***

**Can patients be empowered through rules set by authorities?**

British general practice development and research has always been a great inspiration for Norwegian colleagues. The Norwegian parliament has decided that a list system for general practice will soon be implemented. Yet, apart from this, health care is still very differently organised in Britain and Norway, and several of the reforms listed in the NHS Plan refer to matters beyond the mind and interest of a Norwegian GP. The plan announces extensive ambitions on several levels, supported by promises of funding.

Since I am doing research on patient perspectives, my attention was attracted to Chapter 10: 'Changes for patients' — excited to learn how British authorities would seize the opportunity to make a leap on patients' behalves.

I am sorry to say that my expectations were not fulfilled. The plan presents a number of formal efforts to secure patients' rights, regarding information about treatment in general and for the individual patient, increased opportunities for choice of doctor and hospital, extended options for complaints, assessment of performance in health care, and patient representation throughout the NHS. Such initiatives are necessary, but far from sufficient to deserve the notion of fundamental reforms.

The plan does not question the essential presumption of making patient perspectives valid in health care, which concerns the unpleasant matter of power. Patient perspectives can only be implemented by challenging the sovereignity of medical knowledge, health care authorities, and individual practitioners. To make it very brief: if patient satisfaction is to be measured by answers to questions posed by the service providers, and dissatisfaction requires extensive complaint measures to be taken, no fundamental reform has taken place. Patient empowerment requires that not only answers but also questions are voiced by patients themselves. Admittedly, such changes are not easily implemented in a plan document, but the NHS reform is nearly empty of intentions on this level.

Authorities on all levels may find such reforms too bothersome. If so, the balance of power in health care may remain undisturbed, wrapped in nice slogans about changes for patients.

***Kirsti Malterud***

The 144-page NHS Plan makes encouraging reading and, combined with the considerable injection of resources of money, staff, hospitals, and primary care facilities, should make us believe that change and improvement within the NHS is at last achievable.

There is to be an increase in the number of doctors trained with 450 more GPs by 2004. But is that enough? The role of the nurse is to be extended with nurse consultants, nurse practitioners, nurse prescribers, and nurses in charge of triage. The new resources will allow for new NHS facilities bringing together primary, community, and social services under one roof to make access more convenient for patients. And by 2004 there will be 500 'onestop' primary care centres. Convenience is indeed important but it must not be at the expense of creating a large impersonal environment. The increasing role of the nurse must not prevent access to a general practitioner trained to diagnose.

It is good to see increasing emphasis in the use of electronic facilities. The electronic patient record with patient access will become available. Inevitably in a document of this size, finer details are not described. Will all staff, community and social services have access to all my notes? And just as important, will their patients have access to all their notes? Can we totally rely on an all-electronic system? The use of NHS Direct and IT for patients and their relatives to access medical information may be beneficial but it cannot replace contact with an individual GP. Furthermore, continuity of care may be eroded.

It is quite clear that the intention for the involvement of the public and patients in the many aspects of the organisation of the NHS can no longer be token. There is to be greater lay involvement in the regulatory processes and patient choice is to be strengthened, with more information published about GPs to make it easier for patients to choose. What is not clear is whether that will be the responsibility of the individual practice to produce.

From the patient perspective, there is emphasis on openness and transparency about standards and information about treatment options. I am particularly pleased to see something that I have already written about in the *Journal*, i.e. that letters between clinicians about an individual patient's care will be copied to the patient. It is a sure way of increasing patient information and involving them in their treatment and care.

***Patricia Wilkie***

*And so it came to pass that the One did proclaim to the People:*
*'Make haste to the Healers, and ye shall be ministered to speedily, for I have made them strong.'*

*And lo, the People rejoiced and made haste.*

*And the Healers did ask of the One:*
*'But how shall we serve your will, for we are small of number and heavy of burden?'*

*And the One did reply:*
*'I have made you strong by giving the blessing of my will. For my will shall prevail and it shall be done.'*

*And the healers were sore afraid, being cleft between the will of the One and the wrath of the People and did ask again the question of the one:*
*'But how shall we serve your will, for we too love the People?'*

*And the one did reply:*
*'I shall split the Healers asunder that they may no longer oppose my will, for my will shall prevail.'*

*And so the Healers were exiled to new tribes in foreign lands and they did mourn the passing of the Old Ways.*

*And it came to pass that the People did mourn the passing of the Old Healers and did ask of the One:*
*'Why has this happened to us?'*

*And the One did say:*
*'For the Healers did oppose my will.'*

***Alex Thain***

9

# Postcards from a New Century

## Playing at doctors and nurses — more to divide us than unite us?

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

We have been playing at doctors and nurses for a long time now. Most of us would subscribe to the doctrine of teamwork based on respect for each other's skills and professionalism, but how honest is this mutually regarding vision? What really lies behind the cosy rhetoric of multi-professional teamwork? And how can the situation be improved?

The relationship between GPs and their nurse colleagues has been characterised through the use of three key dimensions: gender, professionalism, and employer–employee relationships. All three elevate GPs in terms of power — and all three are changing.

The profession of medicine has always espoused the scientific — and archetypal male — qualities of technicality, rational detachment and control. In contrast, nursing has embodied the 'female' qualities of empathy and interdependence. Feminist commentators have drawn parallels between the traditional model of the family unit and the gendered relationships within health care services. In this scenario the doctor is the husband, doing the thinking, the nurse is the wife, taking delegated instructions for manual tasks and the patient is the dependent child, mostly passive but occasionally difficult. The doctor 'cures', the nurse 'cares' and the patient eats his greens and takes the tablets. It may be uncomfortable to admit it, but such stereotypes still structure the emotional topography of many primary health care teams.

For decades the two professions have also been locked into a different, barely articulated minuet about professional power. Both professions strive to do their best but internally nurses grind their teeth at having to get a GP to sign every prescription for hydrocortisone cream while GPs silently rage at how practice nurses always seem to need a stiff protocol or two before they can start work.

Employee status also takes its hidden toll. Practice nurses know that GPs earn much more than they do and the small business arrangements of general practice add insult to injury with nurses routinely excluded. And outside, in the wider hierarchies of professional nursing, the fact that practice nurses are actually employed by doctors carries its own subtle stigma. All this militates against the possibilities of true, collegial teamwork.

So much for history — what of the future? Nurses working in primary care are currently taking on an increasing amount of the work previously undertaken by their medical colleagues. The modernisation agenda will push this further and faster. However, on a day-to-day basis this expansion of work seems to have had little impact on the subordinate power position of nurses. Medical dominance of PCG boards has also been a public confirmation for many nurses of GPs' desire to control and dominate the primary care agenda. They feel their views and experiences are devalued and are frustrated by their inability to influence future strategic planning for services. This subordination is reinforced by the predominant tone of the Government's modernisation agenda where leading edge nursing is publicly portrayed as 'freeing up more doctor time'.

GPs meanwhile are feeling more uncertain than ever before. The old patriarchal model of independent contractor and breadwinner is withering by the month. Salaried service and PMS beckon but, like all new worlds, hold as much fear as promise. Add to this the uncertainties created by the demise of community Trusts and the immanent transfer of many health visitors, midwives and district nurses (and possibly, eventually, practice nurses) to PCT employment and you have a potent mix indeed.

These changes sharpen the old dilemmas: Should we be aiming for a relationship of equality or are patients' interests best served by a continuation of dominant and dominated? What difference will PCTs make? And if most doctors and most nurses are ultimately employed by PCTs will this solve all the difficulties?

So much is changing that it is hard to be certain of the answers to these questions. However, some things are clear. First, employment by PCTs — be it for GP, practice nurse or health visitor — is a radically new step that could end the employer–employee relationship between GP and community staff. Secondly, general practice is becoming much less 'male' as the proportion of women principals rises. This effect will become more pronounced as the generation of women who entered general practice 10 to 15 years ago increasingly return to full-time work. These two changes have the potential to remove the employer–employee dimension and reduce the male–female divide. Thirdly, the consumerist patient is also growing up. Armed with Internet printouts he or she no longer resembles the dutiful child but rather the truculent, unsure adolescent, questioning the right to authority of those who they earlier felt had the wisdom and experience to guide them. Like all adolescents he is unlikely to be sympathetic to parental needs.

Finally everyone, but especially GPs and staff transferred from community trusts, are experiencing high uncertainty and new roles. While uncomfortable, this also offers the chance to build new relationships between doctors and nurses.

To take advantage of these opportunities we

**Further reading**
Salvage J, Smith R. Doctors and nurses: doing it differently. *BMJ*; **320:** 1019-1120.
Wicks D. *Nurses and doctors at work: rethinking professional boundaries*. Buckingham: Open University Press, 1998
Allen, D The nursing-medical boundary: a negotiated order? *Sociology of Health and Illness* 1997; **19(4):** 498-520.

need to be more aware of the common ground shared by the two professions, rather than focusing on our differences. Both GPs and nurses have at the core of their work a tension between the empathic, patient-inclusive nature of their work and the need for technical expertise in diagnosis and treatment. Maintaining the balance between these two may become more difficult as the language of clinical effectiveness and protocols becomes dominant. GPs and community nurses need opportunities to share their philosophies of practice, their methods of clinical decision-making, and their views of future ideals. There is much that we can learn from each other. The progress, tentative and patchy though it may be, towards interprofessional learning is the means through which this sharing can begin.

As nurses become more proficient technically, it seems likely that the edges between the two professions will blur. As we move through the 21st century we may see the emergence of a single generic primary care professional. The introduction of nurse practitioners and nurse prescribing could be seen as the first steps along this road.

All these changes would be enormously helped by national agreements on accountability, so that GPs no longer feel the necessity to control nurses on the false premise that they will be held accountable for potential nurse errors.

So where does all this leave us for the 21st century? To return to the family analogy it seems clear that we have already reached the point where the patient has become the questioning and opinionated teenager, where the husband's opinions and decisions are disputed and where the wife is thinking for herself. A positive 'post feminist' analysis might say that we have now got it right, with equal division of labour in the home and truly mutual respect for the skills and capabilities of each partner. Alternatively it might be that we are now in a position where people are able to make 'laddish', postmodern sexist jokes without fear of recrimination and women, despite having broken through the glass ceiling are still having to also do all the organising and maintenance work for the home.

Translated into primary care this would mean that teams may have developed a culture within which all are respected for their differing contribution, where decisions are made inclusively, and where it is acknowledged that working together achieves more than the sum of individual contributions. Alternatively, it may be that it is possible for us all to view the difficulties of our relationships as illusory and make ironic jokes caricaturing each other, while nurses increasingly take on the most tedious tasks of their GP colleagues in addition to their current workload, and GPs continue to lose their sense of identity.

How we choose to analyse the present and how the future pans out in practice is down to all of us. We need to be grown up enough to acknowledge and discuss the problems we are encountering together. We need to share our frustrations, insecurities, and hopes for the future. Just as some families have achieved a balance of power, responsibilities, and individualism, so it must be possible in primary care teams, if we want to make it happen enough. Of course, we may need the services of Relate to help us negotiate the difficult patches but if we act now and stop pretending that our interprofessional relationships are fine then together we may find a way to rebuild our professional identities on a new, partnership basis.

**Anne Rowe**

## Caught in the web

What makes the world wide web such a mighty phenomenon? Many answers of course, but in part it's due to it's very web-ness: millions of sites linked by a distributed, completely unhierarchical technology. Until recently, the economies of scale and capital meant that we mostly created monolithic, pyramidal organisations, such as Ford, the Army – and the NHS. Now many hierarchies seem destined to become webs, or at least more weblike: In economics, top-down planning has long given way to the distributed 'wisdom' of the market. PCs displace mainframes and the new 'Bluetooth' chip will enable machines and appliances to link up into an ever denser web. And in the public sector calls for 'partnership' can be seen as a demand that we give as much weight to horizontal connections with other organisations as to vertical accountability.

So what of primary care? Interestingly, general practice already consists of a web of 10 000 independent units. This has enabled us to adapt comparatively quickly to a rapidly changing world. Traditionally, however, general practices have simply been autonomous — controlled neither by health authorities nor influenced by their neighbours. PCTs offer new possibilities. Some will emphasise a hierarchical approach and stress account-ability, consistency, and control. Some will value diversity and some — like others before — will give up any attempt to herd their unruly flotillas of bloody-minded practices.

Webs offer different lessons. Webs typically excel at delivering multiple 'good enough' goals; they thrive on exactly the kind of competitive/collaborative relationships that often exist between practices; and order (such as it is) tends to emerge from the bottom rather than be driven from the top.[1] Happily, PCTs will create a rich web of inter-practice links — shared data, common staff, single IT platforms, agreed care pathways. On this reading a very modern phoenix is arising out of the ruins of independent contractor status.

1. Kelly K. *Out of control - the new biology of machines.* London: Fourth Estate, 1995.

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**The Mating Mind: how sexual choice shaped the evolution of human nature**
**Geoffrey Miller**
Heinemann, 2000
HB, 537pp, £20.00, 0 434 00741 2

Geoffrey Miller's new book confirms that we are living through a golden age for popular science writing — especially on evolutionary topics. This provides a unique chance for the general reader to be entertained and amused at the same time as grappling with sophisticated theoretical arguments at the cutting edge of contemporary science. *The Mating Mind* is serious scholarship that is also accessible to any interested reader of the *Journal*.

Everyone thinks that they understand evolution by natural selection. After all, the theory was summarised in half a dozen sentences by Darwin in his preface to *The Origin of Species* in 1859. But it would be more true to say that nobody really understands natural selection, since important discoveries continue to be made up to the present day. Sexual selection has been known about since the 19th century, but only in the past couple of decades has its importance been recognised.

Sexual selection is a type of natural selection where the selective force is competition over mates and matings. The classic example is the male peacock's tail, classic because the tail is so cumbersome and bright that it substantially reduces the likelihood of survival of males by making them vulnerable to predators. The selection force is female preference: males with the largest, brightest, and best maintained tails get the lion's share of matings and transmit copies of their big-tail genes to future generations. Males with small tails may fly better, be better camouflaged, and live longer, but because females will not mate with them the genes from the short-tailed birds rapidly become extinct.

So, the advantages of health and longevity can be overwhelmed by sex appeal. This can happen for various reasons. There may be an accidental linkage between genes for female preference and male traits. Or the male trait may signal 'better genes' in some way. For instance, a cockerel's comb seems to advertise the state of his immune system — a bright red comb gets the hen, probably because a mottled comb indicates parasitic infestation. Indeed, since masculine traits are mainly caused by immunosuppressive hormones, such as testosterone, only the best genes can make a male that is both 'macho' and healthy. By picking a healthy, bright-combed cockerel to father her chicks, the hen also picks the best paternal genes.

Geoffrey Miller probably knows more about sexual selection in humans than anyone in the world and his book is probably the most important contribution to this literature that has so far emerged. It really is packed with ideas: a feast of creative thinking and surprising insights. He adopts an impressively critical approach, where nothing is put forward without examining it from several angles. For example, Miller gives an account of the subject matter of his PhD thesis, then proceeds to critique this theory in relentless detail, eventually concluding that it is not really very well supported. Such impartiality is rare in science!

Miller's book is not so much a theory as an extended illustrated argument of the importance of sexual selection, making the case that this perspective deserves much greater prominence in evolutionary biology, especially in regard to humans. Instead of regarding human behaviours as being a by-product of survival strategies, they can be regarded as sexual 'displays' akin to the peacock's tale. This may help underpin human behaviours of a creative type, such as arts, entertainment, and humour. These highly competitive areas are (quantitatively, at least) dominated by young men. Those who achieve eminence in these fields are rewarded by increased sexual attractiveness — think of the heroes of rock music. Like the peacock, these men are 'strutting their stuff'.

So, *The Mating Mind* can stand on a bookshelf beside such recent evolutionary classics as Helena Cronin's *The Ant and the Peacock*, Daniel C Dennett's *Darwin's Dangerous Idea*, Matt Ridley's *The Red Queen* and *Origins of Virtue*, Jared Diamond's *Rise and Fall of the Third Chimpanzee* and *Guns, Germs and Steel*, Robert Wright's *The Moral Animal*, David M Buss's *Evolution of Desire*, Wrangham and Peterson's *Demonic Males*, and many others. If the general reader wants to know about evolutionary biology, especially as applied to humans, then they need hardly look further than these, and many other excellent popular accounts referenced in *The Mating Mind*.

And since the application of evolutionary theory to humans is an activity still in its adolescence, there remains a great deal of work to be done. It was reading Matt Ridley's *The Red Queen* six years ago, which stimulated me to switch my main academic efforts away from epidemiology and towards evolutionary psychology. This discovery has led me into the most intellectually fulfilling years of my academic life so far. Maybe *The Mating Mind* could do something similar for you?

***Bruce Charlton***

**Ritalin Nation**
**Richard DeGrandpre**
W W Norton, July 2000
PB, £9.95, 284pp, 0 39332025 1

What on earth are we doing to our children? I don't know about you, but I seem to see an increasing stream of despairing parents who have lost control of their offspring. They are clearly at the end of their tether, fraught, frazzled, and frightened. Their sons and their daughters are beyond their command, though when Bob Dylan wrote those words I doubt if he was referring to six-year-olds.

GPs and health visitors see one dysfunctional family after another, families who plead that 'something must be done'. We offer advice, and counselling, and care. We refer on to family therapists, and child psychiatrists. Diagnostic labels such as ADHD become applied and more and more of these children end up on some form of medication or other.

Improvement on drugs such as Ritalin (methylphenidate hydrochloride) can be remarkable, and parents are usually relieved and grateful — as are their teachers. You can't argue with success. But perhaps we should.

*Ritalin Nation* is an intriguing book that questions the concept of attention deficit and hyperactivity problems as being medical problems worthy of medication, and instead looks at what society is doing to our children. And it ain't a pretty sight.

Our culture has become obsessed with speed. We want the best and the quickest, and we want it now. Our expectations change constantly, and we are always after the latest upgrade for whatever we are using. We buy a new computer, or video, or TV, and almost immediately want an even newer model. This book simply points out what impact this advancing technology is having on us, on our attention spans, awareness, desires, and frustrations. And if it causes problems for adults, can you imagine the effect it has on our children?

DeGrandpre quotes a teacher as saying, 'The reason our children don't follow directions is that they're tuned out. These children don't listen. They have so much stimulation — they are used to the TV blaring, the stereo, the household commotion. I'm not sure so many are ADHD: they're just restless because they don't have anything inside. They are so used to being entertained'.

I have often been puzzled why an apparently stimulant drug such as Ritalin should have a calming effect in these children. It now makes perfect sense. Could it be that the drug provides children with a relatively intense, behaviourally independent source of stimulation, so the child no longer needs to leave his seat to get the required level of stimulation? Is it like methadone i.e. not eliminating the addiction (to stimulation) but simply maintaining it in a less destructive fashion?

And parenting has changed too. In the past, parents whose psychological needs were not met by vacuous home lives suffered psychological and emotional problems that led to conditions such as depression and drug abuse. Now everything has changed, and it is the children who are more likely to have unmet psychological needs and suffer from emotional and behavioural problems. Life has become so hectic for all of us, and the sort of quiet, unhurried simple time together that gives a child security has become increasingly difficult to find. Children need time with their parents — but not short sharp snatches of ludicrously named 'quality time' They need nonsense time, and wasted time, and time just spent together. And they aren't getting it.

Indeed most of a child's time is now spent in front of a television, usually armed with a remote control scanning from channel to channel. These children need genuine stimulation, with running, jumping, playing, cycling, sports and swimming, but parents have become so paranoid of the risks of letting their children outside that they coop them up indoors and then come to the doctor for help with the consequences.

The author's argument is a powerful one. Society has clearly got it wrong. Unfortunately, when faced with yet another hyperactive child I still don't know how I can use these insights. Like everyone else, I need a quick fix too, and a complete restructuring of society's values before morning coffee is, I suspect, out of the question. But if child behaviour is an interest of yours, have a look at this book. You won't be bored.

***David Haslam***

**Cardiology on the web**

When starting an internet search it is often helpful to put the specific term you are interested in into any general search engine, such as Google (**www.google.com**). Even unusual terms such as 'hypertrophic cardiomyopathy' return useful hits, often quite specific. In this case, among the top 10 hits, you will get **http://www.cardiomyopathy.org** a site for and by patients with much of interest to the physician. Typing in terms such as 'cardiology' produces a list of all the different worldwide associations, scrolling down will lead you to the one you want, whether American, British or paediatric. For the latter type, the best site brought up by this search was **http://www.rchc.rush.edu/**, a children's heart hospital with extensive teaching materials for professionals. General organisations, such as the American College of Cardiology (**http://www.acc.org**) have protocols and guidelines (admittedly North American) with many useful links and articles. The British Cardiac Society (at **www.cardiac.org.uk**) has a potted history of the speciality. Cardiology started in the UK as a separate speciality after the First World War although there had been a journal in 1909 and occasional conferences. Details of how to contact the society and current conferences are there but this is about all there is. In contrast, a site with lots of information but still fairly difficult to find your way around is **http://www.Cardio.net**. There is a wealth of patient and doctor information including PowerPoint presentations of the results of recent significant trials, however registration is required to gain access, which may put people off.

Ischaemic heart disease has a huge web presence. The British Heart Foundation (**www.bhf.org**) has much of interest, mainly aimed at patients. The Health Promotion Professionals web site **http://www.healthpro.org.uk** has a wealth of leaflets and information about many aspects of coronary disease as well as links to other health information sites, including the Family Heart Association at **www.family heart.org**. A site aimed at GPs and run by a British GP, Chris Burton, can be found at **http://www.medicine21.com/heartGP**. He also writes a regular column about cardiology for GPs on the Doctors.net.uk site, **http://www.Doctors.net.uk**, where many other reviews, resources and links for all specialities as well as cardiology can be found.

***Trefor Roscoe***

# Does the *British Journal of General Practice* have sex appeal?

## Non!

The College and this journal have for many years been accused of being out of touch with the average GP. Registrars take the MRCGP as a means to getting a job, and rarely with any great noble aim of joining a Royal College. Most, once the pressure of exams has become a distant memory, will join the majority of their new colleagues in hardly ever opening the covers of these pages. Once the reality of general practice without the protection of a trainer and mentor hits home, the well intentioned idea that they will spend time each week studying and reading papers simply becomes a memory for many. The piles of unread journals will sit gathering dust in a quite corner, the only recognition of their presence being an occasional guilty glance, and a further resolution that 'I must get round to reading them'.

To encourage busy GPs, old and new, to read something like the *Journal* it needs to be attractive and easily accessible. For many years it was anything but that. It was like trying to wade through treacle, but without the sweet taste. However, when the Back Pages were introduced I thought things might change. I thought that at last the Journal would become readable, and for a while it did. I enjoyed turning to the back first of all with a degree of anticipation, to read the collected wit and wisdom of people who seemed to know what real general practice was all about. They wrote in a way that made it easy to pick up the journal during those rare, quiet five minutes when a patient fails to attend an appointment, or is late. They were the sorts of brief and understandable articles that you could read over coffee, while at the same time half-listening to the conversation elsewhere in the common room.

However, once again, things are changing. It seems to be the same authors appearing each month, and the writing seems to becoming ever more impenetrable to simple souls like me. Once again, the *Journal* has the air of being only for the learned, or the academic who has protected reading time, or in particular for those with a diploma in jargon creation.

Clearly, there is a need for high quality primary care research to be published and discussed by as many people as possible. I also recognise the need to have a journal that is respected by a world medical community as being 'worthy'. But should that be completely at the expense of ordinary, membership fee-paying folk like me who wish to access articles and papers in an easily readable form?

It is well recognised that research in primary care is at a low level and needs to be encouraged. Surely, if primary care research is to get into the blood of the majority of full-time GPs, the way it is presented in *our* journal needs to be attractive, exciting, and accessible. The *Journal* needs to be *sexy*.

The Back Pages were a start. It would be hoped that someone picking up the *Journal* with the sole intention of reading the Back Pages, might find themselves straying to the research at the front, and then who knows what could happen. Unfortunately, these pages, too, seem to have been taken over by the academic. Now is the time to reclaim them for the common man/woman!

**Richard Vautrey**

## Oui!

Richard Vautrey's criticisms cannot go without comment. Not because they are new (we have all heard them before), nor because they are easily seen off (some at least are entirely justified), but because they give us an opportunity to clear up some misconceptions about the *Journal* that we think may be shared by many members of the College.

The core purpose of the *Journal* is to publish high quality peer-reviewed research conducted in and about primary care to enhance the quality of the care that patients get, both here and around the world. It is a gift that the College gives to the world as one of the ways in which it furthers its own core purpose. This makes two consequences inevitable. First, the constraints of scientific writing make the bulk of the *Journal* hard work. Of course we should work hard to avoid the jargon, and we can (and should) try some journalistic tricks to engage readers in the research. But it will never be the kind of thing that can be fitted into five-minute gaps between patients. If you want to engage seriously with primary care research then you have to take time to do so, to think about both the validity and the implications of what you have read. Secondly, very little of what is published will or should have an immediate measurable effect on everyday clinical practice. To imagine that it would is to misunderstand both the research process and the web of factors that influence decision-making in medicine. Knowing that every paper is only a sample of reality, that each one is only one piece of a much bigger jigsaw, and that the knowledge jigsaw is part of a much bigger one that includes patients' values, psychosocial factors, fashion, and experience, the most that we should hope for is that a substantial number of the papers we publish make a contribution, however small, to the discipline.

As well as clearing up misconceptions about the *Journal*, Richard's letter allows us the opportunity of trumpeting Things To Come. Behind the scenes in the last six months, we have been working hard to change the *Journal* very much for the better. The College has invested heavily in the *Journal*, doubling editorial resources and funding a new on-line presence. The latter is a major exercise fraught with technical difficulty (and not wholly running to time), but we confidently expect to deliver a world-leading family medicine journal on-line next year. Moreover, from January 2001, readers can look forward to a re-designed paper journal that, at last, is a pleasure to look at and to handle. Less romantically, we shall issue clearer and more comprehensive 'Information for Authors' very soon and, to entertain dedicated *Journal* anorak-wearers, new forms of peer review and new ways of harnessing the talents of our editorial board are under development. We aim to process submissions to all parts of the *Journal* more efficiently than before, reducing embarrassing delay from submission to publication. Your *Journal* is not standing still.

The Back Pages are more easily dealt with. Richard Vautrey is right to complain that the 'usual suspects' appear too frequently in this section, but there again we depend upon authors and readers submitting material, and too few of you do. If the *Journal* is to reflect the 'wit and wisdom of people who know what real general practice (is) all about' then such people have to write for us. We shall be calling for new volunteers shortly, to freshen our mix. Of course, there should also be room in the Back Pages for more difficult and challenging writing and we reject Vautrey's notion that our articles must be brief to be understandable. But we'll try to be brief when we can.

If the *Journal* is always going to be such hard work, why should members bother to read it at all? If they can pick up the summaries from reading 'sexier' publications, such as *GP* or *Pulse*, and if they can develop their clinical practice by sitting at the feet of consultants, would it not be sensible, as Richard says, to leave them in their packets gathering dust? These questions are, of course, rhetorical. Any concerned, responsible, caring member of the College should want to maintain their intellectual curiosity in the scientific base of their discipline, stay open to new ideas (and challenge old ones), and even contribute to the intellectual life of the College by sending lively, opinionated, thoughtful, and downright angry letters and articles to the *Journal*. Send us all your best pieces (easiest by e-mail to **journal@rcgp.org.uk**). We cannot guarantee that they will all be published, or that they will appeal to the heart (or some other part of the anatomy) of Richard and like minded souls. But we promise to be fair and courteous to all our contributors. Oh, and thank you to Richard for this piece. We await the next few with eager anticipation.

**David Jewell**
**Alec Logan**

## neville goodman

**More irony**

Just occasionally, there are revelations of the surreal splendour that is human existence. When a train seemed to be on an unusual return route from Paddington, I asked whether we would arrive in Bristol on time. The inspector looked puzzled.

'Yes, we're on time,' he affirmed, and made to move on. I retrieved my timetable from my top shirt pocket. Top shirt pockets are incredibly useful for rail tickets, parking vouchers, and rail timetables — even though only the rail timetables are sturdy enough to withstand a biological wash at 55°C, and London Underground machines reject the parking vouchers. A related confusion causes difficulties when electronic hotel-room keys fail to produce money from hole-in-the-wall machines. These keys are, however, ideal for scraping ice off the bottom of cross-country skis.

Back to the train. I was about to correct the inspector's timing, but he nodded knowingly and said, 'Ah, you're looking at the timetable!' It was a sublime moment. It got me thinking about useless things. I don't mean completely useless things, such as televisions that don't work. I mean useless things with irony, which had an outing in this column in May.

We'd lost a pair of scissors. A colleague told me an important fact of life for the comfortably off. Don't have just one pair of scissors, which is always getting mislaid; buy another one. When the first pair turns up, put the other pair in a different room. Eventually you have a pair of scissors in every room but so what? That's the advantage of being comfortably off. So I bought another pair. It came attached to a stout piece of cardboard that needed a pair of scissors to release it. Useless with irony, much like the hand drier in a pub toilet that burst into life only when my hands were to one side of the air stream.

It happens in medicine too. Gleeful at having secured an intravenous cannula in a patient with 'no veins', I discovered that the cannula hub was split. Or there was the syringe whose neoprene bung, when I attempted to take a blood sample, turned out not to be attached to the plunger. Weirdest of all was the ECG machine that continued to show regular sinus rhythm with normal complexes after I had unplugged the patient lead from the machine. In a roundabout way it got me wondering why passengers get off trains clutching their car keys in their hands, even though they still have to carry an overnight bag and a briefcase across a bridge, and their car is a quarter of a mile away.

**Nev.W.Goodman@bristol.ac.uk**

# our contributors

**Bruce Charlton**'s magnum opus, *Psychiatry and the Human Condition* (Radcliffe, 2000, 1 85775314 3) transcends a truly horrible cover and will be reviewed in the October issue of the *Journal*
**Alison Craig** works for Pesticides Action Network in London
**Neville Goodman** should have an intimate Edinburgh Festival Fringe one-anaesthetist show under his belt by now, but he has yet to write it. For the moment he continues to gas Bristolians
**Dorothy Logie** directs, quite wonderfully, primary care in the Borders
**Alan Munro** didn't win the Three Peaks Race this year and we're not at all surprised. While his oarsmen oared, Munro reclined on the quarterdeck quoting Homer, the epitome of a medical columnist, about ship...
**Trefor Roscoe** is a GP informaticist from Sheffield, as many of them are...
**Richard Vautrey** is a GP in Leeds

***nhs plan...***
**David Haslam** is a GP in Cambridgeshire, the author of several useful guides to bad boys, chairs the RCGP Education Network, and is an authority on deadbeat 70s rock-folk combos
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**Kirsti Malterud** is professor of general practice, University of Bergen, Norway
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**Alex Thain** is a 'fairly ordinary GP with a rather twisted slant on things', from near Inverness, Scotland. He relies heavily on humour to hide his insecurities
**Patricia Wilkie** chairs the RCGP Patients' Liaison Group
**James Willis** is a GP in Alton, Hampshire. His forthcoming *meisterwerk, Friends in Low Places,* will be available from Radcliffe in time for Christmas...

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

# alan munro

**Heroes**

Three thousand years ago, Homer's heroes besieged Troy, on account of beautiful Helen, wife of Menelaos, brother of Agamemnon, greatest of the kings of the Greeks; she who scandalously absconded with Paris, son of Priam, king of Troy. Steamy stuff.

Achilles, the Greek superhero, quarrels with Agamemnon over the spoils of war — not gold or territory, but Briseis, gorgeous daughter of the priest of Apollo. Agamemnon confiscates her, literally, from the bed of Achilles. The Greek's incomparable athlete of war withdraws from the fray, profoundly in the huff, compromising the whole Greek war effort, with great loss of life. A quarrel about a girl within a quarrel about a girl, and looming tragedy.

Twentieth century commentators seem oddly squeamish about this. They weakly emphasise the recovery of Helen's possessions and discourse interminably upon the importance to Greek heroes of their public reputation. But why, they never ask, is reputation important? Ask any chimpanzee — breeding rights, of course. Men and chimps fight to breed. Fight in the broadest sense; the right networks and craftiness are important too. Homer's other superhero was the outrageously subtle Odysseus, who competed pretty effectively when it came to sorting out those who threatened his genetic ambitions.

Homer and his heroes never lose sight of the ultimate goal. Reputation and wealth were mere means to an end. The heroes were single-minded dynastic egoists, whatever gloss subsequent culture may put on it.

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Thirty or so years ago, I embarked on an ameliorated, 20th-century Trojan war, a sorting and sifting of young lives and reputations in the competitive, though bloodless, tertiary education system. Along with 150 other recruits to medical school, I heard an elder of the faculty expatiate upon the nobility of his profession, and invite those of us not morally up to it to make an early exit. Looking around, I saw a lot of spots and nascent facial hair but no clear signs of exceptional nobility.

Thus reassured, I permitted myself the reflection that I, at least, was there on account of the constellations of adoring and provocatively uniformed nymphs who surrounded the television doctors of the time. Far from preoccupied with the ethics of medical practice, I was palpitatingly impatient to explore in its uttermost detail the sexual charisma of the stethoscope.

The veneer of culture is a delicate membrane, a filmy disguise of our underlying nature, a confection of proximate causes which obscure the unity of human life and Tennyson's nature, red in tooth and claw. Russell reckons that Greek philosophy, after the admirably detached Democritus, was altogether too fascinated with the splendour of man, starting with Socrates and his enthusiasm for faintly transcendental ethics. Man ceased to be part of the universe but existed, potentially at least, on an exalted moral plane, separate and god-like, allegedly.

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The faculty's old buffer was right, at least in the sense that our customers are exposed to awful risks if we are not noble. Yet I doubt if we were noble at the outset, still less do I imagine that anything was done to make us more noble in the years that followed. Homeric heroes, to a man, seems more likely, unknowing adventurers on behalf of tiny packets of nucleic acid which themselves aspire with the gods to immortality, but confer on their servants only short lives and a certain capacity for self-deception.

Should we admit only women to medical school, perhaps? Might nurturers make more reliable doctors than fighters?

Or maybe there is nothing else for it but a Draconian GMC?