The British Journal of General Practice

Viewpoint

Injustice perpetuated

After a protracted delay of 16 months, the Government finally published its response to the Royal Commission on Long Term Care in July as a supplement to the National Plan for the NHS.[1] The response begins by describing the present system of care is confusing, unfair, and unresponsive and then goes on to lay out plans that will perpetuate just such features.

The principal majority recommendation of the Royal Commission was that 'the costs of care for those individuals who need it should be split between living costs, housing costs, and personal care. Personal care should be available after an assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means.'[2] This recommendation arose out of the Commission's recognition that no-one needs, or wants, help with intimate personal care unless their health is compromised to such an extent that they are unable to do these things for themselves. Personal care describes the vast bulk of the health care needs of the frail elderly. It is not medical care, or even, these days, nursing care, but it is essential to the dignity and independence of the chronically ill and is, therefore, undoubtedly health care.

The Commission's recommendation, combined with the Government's very welcome commitment to increase substantially the funding of the NHS, presented the Government with an unique opportunity to regain the trust of older people. This trust has been eroded as the health care needs of older people have been systematically redefined as social care which can be charged for on the basis of means testing. In rejecting the Royal Commission's recommendation, the Government has perpetuated this injustice. Instead, the Government proposes that nursing care should be provided free. This creates an unprecedented and extraordinary situation in which the provision of free care will depend not on an assessment of the impact of illness and disease on the individual patient, but on the job definition of a particular health professional. Is this just? And worse still, as nursing, like medicine before it, becomes increasingly technological, more and more frail older people and those with chronic incurable diseases face the prospect of seeing their health care needs fall out of the definition of nursing and become subject to means tested charges.

For years, the care of frail older people has been blighted by perverse incentives operating across the divide between health and social care. The implementation of the recommendation of the Royal Commission would have helped to close that divide but, instead, the present proposal sets up a whole new raft of perverse incentives. The NHS 'will meet the needs of registered nurse time spent on providing, delegating, and supervising care in any setting'. Primary Care Trusts and local authorities, and eventually the new Care Trusts, on tight budgets, will be under ever-increasing pressure to define the health care needs of older people as social care not requiring nursing expertise. In so doing they will distance older people from the skilled care that they need. On the other hand, the opposite perverse incentive will operate for private nursing homes that may well seek to extend the definition of nursing care and employ more registered nurses whose costs will be covered by the NHS.

Rather belatedly, the RCN has recognised that the proposed definition is unworkable[3] and will undermine movement towards skill mix within nursing teams. Care delegated to health care assistants will be means tested whereas care provided by registered nurses will be provided free. Older people will be expected to pay for less skilled care. Is this just?

The NHS Plan[4] states that the new National Service Framework for Older People will ensure that ageism will not be tolerated 'within the NHS'. The Government's response to the Royal Commission makes it increasingly likely that this will be achieved by yet further excluding the health care needs of frail older people from NHS provision.[5] Ageism will be taken outside the NHS and institutionalised in the artificial divide between nursing and personal care. Is this just?

Iona Heath

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The Back Pages...

"The most advanced, knowledgeable, educated, psycho-analysed, therapised nation on earth wishes to remain deaf to the world around it. Is this attitude sustainable on one small planet, which is rapidly warming up?"

Dorothy Logie
in *One Small Planet*, page 842

"When Frankenstein was happy, playing with the little girl; it was not a good time to go near him with a torch ..."

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news

Herding Cats — Can Leadership be Taught? Views from the world of medicine, defence, and academeme

Introduction
Doctors have long assumed the position of team leaders but they have largely been replaced in this role by others with teamwork skills in this field. The NHS and the RCGP have now focused on leadership as an issue within the Health Service of the new millennium and Wessex Faculty of the RCGP devoted their Summer Symposium to this topic, taking views from a local GP, the military world, and a management academic.

The GP view — where are we now?
A new era has dawned in medical politics, with the RCGP and the GPC working much more closely together. They have retained their independent thinking and ideas but have decided to bury the hatchet for the good of the profession. The questions now to be addressed are: Is leadership nature or nurture? Are we born with leadership skills or can these skills be taught or learnt? What are leadership qualities? Many GPs are chairpersons but what is the difference between a Chairman and a Leader?

We can learn from politics and many GPs already dabble in this area. Political leadership takes different forms but it has been said that 'being in politics is like being a football coach. You have to be smart enough to understand the game and stupid enough to think that it is important'.

There is a huge agenda for change over the next five to ten years and it is therefore essential to the medical profession that leadership skills are learnt. The profession could learn how to identify leadership qualities from others.

The military view
The military devote much training to leadership. So, what are the qualities of a leader in the Armed Forces?

He or she needs to be a competent decision-maker; and a sharer of information; a leader should exercise sound judgement, show humanity, have courage, and inspire loyalty. Finally, a leader should always show confidence and composure and generate respect, not fear.

The industry and management view
The first step in leadership is communication and there are distinct differences between a leader and a manager. The management definition of leadership is someone who has a position in a group, who influences others, and who co-ordinates direction towards a goal. He or she initiates action and may be seen as a role model within and without their organisation. It is important that management and leadership should not be confused. What is clear is that a leader must have good interpersonal skills and empower others to lead.

Conclusion
This multidisciplinary symposium highlighted how much doctors can learn from other disciplines about leadership. The medical profession is perceived as having many of these qualities but perhaps our selection process and training need to identify and enhance these abilities for the good of our patients and the progression of the profession.

Anna S Wilson

A more detailed transcript is available at ***www.rcgp.org.uk/faculties***

QualityCare Steering Group: psoriasis, eczema and acne

A new QualityCare Steering Group, funded by Leo Pharmaceuticals, aims to look at examples of good practice in the treatment of psoriasis, eczema, and acne.

The group is keen to hear about any initiatives that readers may have implemented in their own practice in these areas. They are hoping to document evidence of effective primary care dermatology models and recommendations, that can be used to campaign for funding/resources to improve dermatology care at primary care level.

The group has representation from many bodies representing primary care including the BMA, the Primary Care Dermatology Society, the RCGP, and nurses' organisations.

If you know of any examples of good practice then please get in touch with Carys Thomas at Ash Associates, administrators for the Group, tel: 020 7240 6005, fax: 020 7240 8005; e-mail: **carys@ash-associates.co.uk** who can describe the format for submissions. Don't worry — it should only take you more than five minutes to complete!

Shaun O'Connell

First programme of research for Scottish School of Primary Care

The first programme of research for the newly formed Scottish School of Primary Care (SSPC) was advertised last month. Funding is being provided by the Scottish Executive's Chief Scientist Office (CSO) and the Scottish Higher Education Funding Council (SHEFC). Both organisations have pledged £600 000 each over three years to develop the infrastructure for Scottish primary care research in Higher Education Institutes across Scotland and undertake more research in primary care.

The first research programme concerns the organisation of service delivery, focusing in particular on integration of care across the interfaces with hospital-based and social care; on quality of care; and on user participation. Another main focus will be on improving services in areas of disadvantage, which include, in Scotland, remote and rural as well as urban deprivation. Dr Kathy Ryan, research manager for primary care at the CSO said: 'We hope that this research will be substantial and collaborative in itself — features that are often scarce in primary care research because of the relative paucity of infrastructure; we also hope that capacity and capability of primary care research in Scotland will be enhanced long term'.

The Foundation Phase of the Scottish School of Primary Care was launched by the Scottish Health Minister Susan Deacon on 1 June this year, following the publication of the Scottish Primary Care R&D Strategy 'Shaping the Future'. The School is modelled on the Dutch School of Primary Care and has twin aims. It will provide the high quality research evidence needed to inform decisions made by patients, practitioners, managers, and policy makers; and will increase research capacity and capability within Scotland through increasing the accessibility of education and training in primary care research.

The School will operate as a 'virtual institution' by facilitating collaboration and co-operation between existing primary care research centres in Scotland. It will draw together expertise to develop new research and to build capacity and capability in research throughout the primary care workforce. The Scottish School should act as a focus for continued investment in primary care R&D in Scotland by showing that a cohesive, countrywide approach to research development can bring added value to policy makers and developers.

Further information can be obtained from SSPC's new website: **www.sspc.uk.com**

Sally Wyke

hilarie bateman

The help-seeker's predicament

A couple of years ago three senior colleagues and I were involved in a seminar series for local primary care practitioners based around some of the concepts and recommendations within the MRC Topic Review.[1]

One of the seminars, using the priorities identified by the Topic Review, was devoted to the topic of 'help-seeking behaviour'. Some of our discussion centred around the insight and interest generated for us by the early paper by Zola.[1] This paper drew on psychiatry and anthropology to consider how patients explain the decision to consult a doctor and the influence of the patient's social setting on the actions they take and the explanations they give. In summarising the content of the discussion which ensued, one of my colleagues emphasised the importance of recognising the patient's predicament — a blend of the disease and its symptoms and the experience of the condition and its context as seen through the eyes of the patient.

Now this is probably familiar territory to most of you who are reading this item. Indeed, the theme has been variously researched, developed, and reported in the 25 years since the Zola paper was published. The necessity to manage the experience of illness alongside well founded diagnosis has become increasingly accepted.

But now take a step back to my position. I am a non-clinician with a remit to advise primary care practitioners as they express interest in research activity. My role, like yours, is characterised by the need to respond appropriately to 'help-seeking behaviour'. My experience suggests that this same concept of 'predicament' may be equally applicable in my own setting. When a practitioner seeks my advice about research is it enough to review the symptoms, diagnose the problem and prescribe the solution, or should I seek to understand and respond to the experience and context of the difficulty as viewed through the eyes of the practitioner enquirer?

I suspect my answer would parallel that of the clinician. Of course I should recognise the symptoms and respond appropriately, drawing on the knowledge base of my specialist expertise (in research) but if I am looking towards a solution with which the practitioner enquirer will feel comfortable, a solution which practitioners will develop for themselves and will 'own', then I must also both hear and value how the problem finds its place within the experience of the practitioner. I must outline the choices ahead and their implications in terms that the practitioner enquirer can relate to, and I must respect the practitioner's right, in the light of this information, to choose a path other than that which I might consider optimal.

It is the craft of those offering help to recognise the balance required between the management of the manifestation of the underlying problem and the management of the experience of that problem. And while as 'experts' we may at times have the answer to the manifestation of the problem we must also accept that any answer to the management of the experience is not in our 'gift' but rather a negotiated position to which both the enquirer and ourselves, as sources of expert help, contribute.

These parallels between my role and that of the clinician fascinate me. What remains a puzzle are the suggestions which have on occasion been made to me that I should find a means to ensure progress towards desirable outcomes, that I should move from a facilitative to a directive approach and that I should consider rationing my input by way of sanction for lack of desired progress. Was patient concurrence ever earned in these terms?

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Postcards from a New Century

One small planet

This article is the tenth in a series of 12 commissioned and edited by ***Paul Hodgkin****, and* ***Alec Logan****, Deputy Editor,* British Journal of General Practice*, London.*

Twenty-first century living has become fraught amid media din and 'data smog'. I find it useful to pause, breathe deeply, and reflect on my whereabouts: I am clinging to a tiny planet, rotating around an insignificant star on the edge of galaxies where time is measured in millions of light years. This helps to put clinical care pathways, evidence-based medicine, and re-accreditation in perspective. While we cannot escape the fact that our fate is bound to what is happening elsewhere, in order to remain sane we need to practice Iona Heath's 'oscillating gaze', that balancing act between uncertainty, contradiction, and complexity between the immediate and the long-term, and between the global view and the local.[1]

Recently the journalist Polly Toynbee,[2] repelled by the artificial hype of the American election scene, railed about US political failure to confront its citizens with reality: no cuts but rather huge growth in carbon emissions despite global warming, refusal to sign the comprehensive nuclear test ban treaty, determination to build the dangerous and useless missile defence system, inability to redistribute wealth to its own poor let alone the Third World in debt relief, executions and a prison population greater than any dictatorship, and a political system corrupted by commercial interest. In return, she received an avalanche of hate mail from Americans typified by this message: "I couldn't care less about any country other than my own. The US uses a lot more of the world's resources than any other country — so WHAT? We're feeding the world and our economy is supporting every wannabe economy in the Third World. We don't need you. You need us. It's about time you Eurotrash paid us the respect we deserve'. The most advanced, knowledge-able, educated, psychoanalysed, therapised nation on earth wishes to remain deaf to the world around it. Is this attitude sustainable on one small planet, which is rapidly warming up?

Much the same mood prevailed on the island of Okinawa this summer, where the G8 leaders met in lavish surroundings and spent $500 million wining and dining, but refused to listen to appeals about improved debt relief for the world's poor.[3] The fact that health care is fast disappearing for millions of people and epidemics of infectious diseases exacerbated by poverty are flourishing, did nothing to move the leaders of the richest countries. The very poor countries pay $22 billion dollars a year to the very rich countries: $60 million a day. Is this sustainable in a planet that is seeing the rich–poor wealth and health divide widening to a gaping chasm? The global trend is staggering. In 1960 the ratio of the average income of the richest 20% to the poorest 20% of the world's people was 30 to 1. Now it is 85 to 1. And we are seeing the gap widen within our own societies as well as between rich and poor countries. In America, after decades of spectacular national enrichment, the poorest 20% of Americans earn 9% less income than in 1977.[4]

As GPs we struggle to make meaning of everyday life. We work hard to deliver good health care in fair and equitable ways, to alleviate suffering and improve health, while somewhere out there obstacles stack up that threaten to reverse our hard-won gains. Our efforts (and those of public health) are often aimed too downstream.[5] Atmospheric pollution, poverty, crime, and hopelessness abound. The tobacco industry's sinister and pervasive influence persists. The multinational food industry drives our dietary habits and obesity flourishes despite our strenuous efforts. Wall-to-wall media noise renders our children hyperactive and emotionally disturbed. Drug firms influence our medical education from our first day in medical school.[6]

What really matters?

Our own well being, the future of our health service and primary care still matter hugely. That primary health care contained in the 1978 vision *Health For All* (the Alma Ata) where we try to achieve for our patients a broad sense of physical, mental, social, economic, and environmental well being. A philosophy, echoing the Universal Declaration of Human Rights, that proclaims health as a human right. But the Alma Ata vision of universal access, social justice, and intersectoral action never happened. In the 1980s the political climate changed, giving way to top-down targeted health policies, privatisation, and 'selective primary care'. *Health For All* was pronounced 'too expensive' or 'too utopian'. It was not seen for what it is: an equity-orientated idea which seeks to empower people and address their immediate health needs while simultaneously sowing the seeds for the ultimate emergence of a fairer, healthier world.[7] This definition of primary health care incorporated a new vision of public health, freed from the forces of big business and attentive to the needs of the poor.[8]

Why is primary health care the driver behind achieving such a vision? Because it isn't only about science, the human genome or the latest dazzling advance; it isn't only about doctors, drugs or western medical models; nor is it about medical or political monopolies or big business interests. It is about something far wider, reflective, interpretative of modern living, philosophical about life and death and our place in the universe. It is the long-term perspective in a short-term, anonymous, technology-addicted world. It is about health and not just health care. If we can promote the qualities that define general practice, an awareness of community, equity, and

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fairness, curing sometimes but caring and comforting always, we could change the world.

We are lucky: few other disciplines have such a blueprint. But to promote primary care on a global scale we need to listen to communities' own interpretations of health needs and also incorporate within primary care the best of holistic, non-western traditional medicine. The microbiologists, the immunologists, and the human genomists may be suspicious of this vision, which is a denial of reductionism — the current dominant force in western medicine.

This fear of reductionism may be behind the thinking of President Thabo Mbeki when he questions the causes of HIV/AIDS and delays South Africans' access to HIV drugs. 'Is there another, non-western way, of tackling this epidemic?' he asks. I disagree with his scepticism in this instance, and his delaying tactics, but maybe I can understand why he is asking the question: is Western medicine going in the right direction?

The People's Health Assembly

In December this year the spirit of Alma Ata will be re-awakened. Civil society (non-governmental networks) will form a People's Health Assembly in Bangladesh to re-examine the agenda for health and development for the new century. The Assembly will hear the unheard voices of the sick, of women, of the poor, articulating the problems that are important to them. It will co-operate with all actors in the health field, traditional healers as well as medically trained personnel. It will also formulate a People's Health Charter that will analyse 'people's stories' of health from many countries with examples of success and failures of health care delivery from a grass-roots perspective. Finally, it will make proposals for the future by asking the questions: What do people worldwide want from health services? With the resources we have, what can we afford?

The 21st century

The world is facing a global health crisis characterised by growing inequities within countries and between countries, despite (or because of?) scientific advances. Enduring poverty, an HIV/AIDS epidemic out of control in much of the world, rapidly deteriorating health indices in eastern Europe, persistent racial and gender imbalances, all threaten the fragile health gains of the last century.

Yet there is hope. The last century has seen an emerging ethic of fairness, equity, and well being to which all people are entitled. Since the Universal Declaration of Human Rights over 50 years ago, an ethos of collective responsibility has emerged, epitomised in a series of UN-sponsored conferences on climate change, population, and sustainable development and now the formation of an International Criminal Court. The communal sense of the extended family has mushroomed in the form of civic responsibility. Health is increasingly being recognised as a political discipline, both in terms of resource allocation and of human rights.[9]

General practitioners are good at balancing the biomedical with the behavioural and social sciences. We need to use these skills to look after a new patient, a small, astonishingly beautiful one. Her name is Planet Earth. Sadly she is choking in her own carbon dioxide, rapidly dehydrating, suffering environmental exhaustion and being exploited by a few greedy people. We can argue that we don't have the time to help because we are too busy following guidelines, balancing budgets, and analysing our critical incidents. But if this patient fails to survive, we shall all die. The 21st century brings health workers greater challenges they have never so far faced.

Dorothy Logie

Diagnostics in the Third World

High-tech medicine has often failed the Third World. Recently things have got somewhat better, with Western governments and big pharmaceutical companies finally coming up with deals to get expensive drugs to the populations who most need them. But what of diagnosis? Poor countries cannot afford expensive tests. According to Medicine Sans Frontieres, up to a fifth of all patients diagnosed with HIV in Africa are actually suffering from other, potentially more treatable, diseases.

Enthusiasts can point to several examples of progress. An American biotech company is developing new diagnostics for tuberculosis. Their patch test is impregnated with a tubercle protein called MBP64 which induces a skin reaction in around three days for those infected with TB while staying negative for those who have simply had the BCG vaccination. The same company has also developed a test for drug resistance in TB that gives a result in only two days. Other developments include dipstick tests for malaria and for lymphatic filariasis.

So it may soon be possible to diagnose a range of diseases under the harshest of conditions.

But will these tests come cheap enough to use? As always the answer comes down to economics. For TB and malaria the large Western market means that these tests are likely to make it into everyday practice and at a price that is affordable in the Third World. Other diseases are less favoured: the company making the filariasis test has just sold the patents because it could not make money on the technology. Happily enlightened self-interest does seem to make some progress: MSD and SmithKline-Beecham have just begun a massive drug donation programme for filariasis under the direction of WHO and the new test is being incorporated into this project.

The Economist, 2 September 2000.

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miscellany

Mbeki, HIV, and poverty

In many developing countries the epidemic of HIV/AIDS is a fire burning out of control, consuming human and economic resources and sparking fresh outbreaks in ever-widening circles. AIDS researchers and activists, largely based in wealthy countries, have succeeded in restricting the scale and spread of the epidemic in Europe, North America, and Australia. But in some poor countries, especially in sub-Saharan Africa, the severity of the epidemic is wreaking increasing havoc, reversing economic progress and threatening a downward spiral into chaos.

HIV/AIDS has already led to substantial reductions in life expectancy in several sub-Saharan African nations. Population growth rates, though still positive, have been substantially reduced.[1] Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) likens the impact of HIV in some societies to its effect on the human body, undermining institutions that are meant to defend society — its teachers, doctors, and health services. For example, in the first 10 months of 1998, Zambia lost 1300 teachers to AIDS; the equivalent of about two-thirds of all teachers trained annually.[2]

Until recently, with few exceptions, political leadership to fight AIDS in the most severely affected African countries has been conspicuously absent. Breaking the silence of his predecessor, South African President Thabo Mbeki has taken a keen and controversial interest in the scourge affecting the people of his country.[3-5] Many of Mbeki's policies and pronouncements about HIV/AIDS appear, at best, misguided, including his support for the discredited treatment virodene and the dissident researcher Duesberg. However, it is his suggestion that malnutrition and poverty cause AIDS in Africa that has drawn the strongest criticism.[5]

Yet, like most phenomena, the causal factors for HIV are multifactorial, dependent upon the focal depth of the lens used by the investigator.[6] Transmission of the virus, be it through sexual contact, contaminated needles, or breastfeeding, represents only one link in a long causal chain.

The more distal links in the chain that lead to the HIV/AIDS epidemic in sub-Saharan Africa are undoubtedly complex. They include the poor status of women, certain sexual cultural practices, myths concerning the nature of transmission,[7] and possibly distinct characteristics of the dominant viral subtype.[8] A culture of bravado, denial, and risk-taking, particularly among the young also undermines attempts to educate the public.[9] In turn, underlying these attitudes and behaviours are deeper or more distal factors, chief of which, surely, is poverty.

While poverty is clearly neither necessary nor sufficient for an individual to contract HIV/AIDS, poverty may well be necessary, though insufficient, for an HIV/AIDS epidemic on the scale currently witnessed in sub-Saharan Africa. Similarly, the factors that cause such poverty are complex and contentious.[10,11] Some proximal causes are identifiable. These include debt,[12] unfair trade, the opportunity cost of the arms trade, and corruption in both First and Third Worlds. In turn, economic models of Third World development are either conceptually flawed, systematically undermined by forces in favour of continued inequality, inadequately funded, or all three. Such structural, institutional and conceptual causes of poverty are rarely considered by leaders in the First World.[13]

Although Mbeki's support of causal models for HIV that deny a necessary role for HIV is regrettable and probably harmful, it is equally regrettable that his political analysis of some of the underlying causes of HIV transmission in Africa appears to have been so critically received by a research community, largely funded by the First World.

Poverty is a major, if not the major, deep causal factor for the scale of the African AIDS epidemic. In turn, policies implemented and controlled by the North significantly contribute to African poverty. Perhaps Northern-based researchers,[14] many of whom benefit in some way from these policies, should consider their own denial, as well as that from out of Africa.

Colin Butler

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Donald MacLean — an appreciation

With the passing of Donald MacLean on 30 August, Edinburgh medicine lost one of its most loved and respected sons. Donald's career was spent almost exclusively in Edinburgh, where he graduated in 1949. For almost 40 years he was the best known doctor in the University-based general practice at the top of the Pleasance (the core of the then new University Department of General Practice). Now, 10 years after he retired, patients still talk of him as 'their doctor' and to the end he still thought of them as his patients and friends.

Donald was no mean academic. He was a meticulous researcher, and his work on mycoplasma, psittacosis, RSV, and hand-foot-and-mouth disease brought early recognition. His whooping cough studies in the 1980s made a timely contribution to the debate on the significance of an illness that was much more important than many recognised. Donald taught undergraduates and postgraduates with commitment and enthusiasm throughout his life, and latterly helped develop the Diploma in Community Child Health.

Donald committed generous amounts of time to the work of the Royal College of General Practitioners, both in London (he was a member of the Committee on Fellowship) and particularly in Scotland, where he was its Chairman of Council between 1984 and 1987, and also Chairman and later Provost of the South East Scotland Faculty. He was also much involved with the British Medical Association, winning the Hastings Prize in 1968, to complement the RCGP Butterworth Gold Medal that he won in 1955. His appointment in 1999 as a Fellow of the British Medical Association was the ultimate recognition of a fulfilling and significant medical life.

Donald was a formidable authority on tradition and protocol, correcting errors of commission and omission in his own endearing and sympathetic way; and he was a wise counsel on the art of the possible. Donald and Sheila (also a doctor who worked in the local community) were able to celebrate 50 years together with his four children and six grandchildren (who were as important to him as anything else) shortly before he died.

John Howie

blair smith

Horseman of the Apocalypse

This summer, we paid our first visit to County Sligo in North West Ireland, staying by the foot of Ben Bulben. This is territory closely associated with one of my heroes, WB Yeats, who was born and is buried there. My breath was taken away upon arrival by the sight of the hills, including Ben Bulben, rising from the Atlantic Ocean in the evening light and forming a mysterious and awesome series, quite unlike any other mountain range I have seen. This was a revelation to me, an unexpected epiphany. We explored the beauty close-up from a road called the Horseshoe Drive, noting paths, nooks, crannies, and caves, all of which invited exploration on the way to attainment of desirable summits.

I recalled similar feelings on my first adult drive through Glencoe, the effect of which beauty, unsurpassed (though possibly equalled here), had previously been dampened by childhood familiarity. On that occasion I was able to satisfy my urge and make an excellent assault on Buchaille Etive Mhor. No such satisfaction in Sligo, however. The verges of the Horseshoe Drive were festooned with notices, carefully painted by the landowner, declaring the land's unavailability and privacy. 'Despite what you may have read or heard,' asserted one in bold red, 'there are no walks anywhere in these hills. Private property. Keep out.' (Precise wording paraphrased by memory, but similar). These were the verbal equivalents of high barbed wire fences, and I expected armed guards to emerge if I dared stop the car, or even shift down a gear.

What a pity that the stunning impact of such a landscape should be sullied by this apparent territorial intimidation. I sympathised indignantly with the Aboriginal scorn for the concept of land ownership. How dare one man hold all rights relating to such an ancient, magnificent and (to put it bluntly) big thing? It appears, however, that the story does not end there. Access to the hills had previously been greater (said our local friend), with the landowner, a sheep farmer, expecting no more than the usual respect for crops and flocks. His approach was reversed by an interpretation of the law that allowed compensation lawsuits in the event of injures sustained while climbing or walking on the land. I twist my ankle on the rabbit hole that he failed to plug, miss two weeks' work, and sue him for the cost of a locum. So it is this bizarre mangling of the meaning of human rights that has denied one of the basic ones.

I returned from holiday to find the press ablaze with the same series of stories that had been kindled before I left. The medical profession had continued to blunder from error to error, crashing through negligence claims and overt inhumanity, and displaying tenuous adherence to moral codes. There were record levels of compensation payments by hospitals, and the cost of indemnity insurance was rising exponentially. How, the papers asked, could the public continue to be confident in a profession that produced Shipman, researched unconsenting babies and failed to expunge its incompetent members? What, the same papers asked, would be the effect on society of losing this confidence? Why, none of the papers asked, was such delight being taken by each in the naked exposure of every available example of medical imperfection?

I can't defend true negligence, but do believe that the vast majority of my colleagues are dedicated, hard-working and carry the best interests of their patients. If, however, patients enter a virtual contract with a medical practitioner looking for mistakes, some mistakes will inevitably be found. This can only encourage the practice of defensive medicine, or of none at all. Extrapolation takes us beyond images of the infamous American obsession with medicine and the law. It leads to the vision of a profession with no voluntary practitioners, and a time when deserving individuals will find no cure or palliation, irrespective of scientific frontiers recently breached. This apocalyptic view is reminiscent of Ben Bulben.

On WB Yeats' grave at Drumcliffe is an extract from his own epitaphic poem.

Cast a cold Eye
On Life, on Death.
Horseman pass by.

I understand something of what he means.

essay

On Personal Development Plans

Honey and Mumford[1] suggest that we all have our own preferred learning style and produced descriptors to identify the extreme characteristics of Activists, Reflectors, Theorists, and Pragmatists.

Most of us are, of course, a mixture of all four.

Imagine, in no particular order, how each of these might greet the news that, within the next year, the majority of health professional staff (and that means YOU!) should have a personal development plan.[2]

Doctor T
Mmmm! ... PDP ?

Personal — yes, it should be personal to me if it's to mean something, though of course if some other chap is going to assess it on behalf of the powers that be, it won't be all that personal, not unless I can trust him.

Development — why should I want to develop? Well yes, actually, I do want to develop a bit, but that's only because David's retiring next year and as the new senior partner it will be for me to manage some of that change agenda. David doesn't want developing — except of course in the kitchen and golf departments — and Linda is too busy as a GP, housewife, and mother of three to do much developing.

Plan — good idea. Plan it out. You miss a diagnosis: you put it in the plan, you read up about it and that problem's solved. The waiting lists get too long: you go on a course and learn to inject joints, it cuts the waiting and it earns you some money too. The HImP group produces some guidelines: you put them in your folder and that's what you do.

Yes, sounds sensible enough — now where did I put that draft plan from the PCG tutor?

Doctor R
Another letter from Peter Goodall in today's post exhorting us all to get started (if we haven't already done so) on our personal development plan. He may be clinical governance lead, but that doesn't necessarily mean he knows what's best for me. He's not the only one banging on about them, though — there was that article last week in one of the free papers. That seemed pretty balanced to me, though I wasn't sure that I agreed with her conclusion that the simplest thing was to just get on with it and cobble something together to keep the education police quiet. Perhaps PDPs are here to stay? But over the years so much that is new comes and goes — and comes back again sometimes!

I remember years ago when they told me that CPD was old hat and that we should be thinking CME. And now, blow me down, if we aren't talking CPD all over again.

Perhaps I'll bring it up with the young principals next week — I don't always agree with them, but letting them talk it through often clarifies things for me. Then if it has to be, it has to be — I've put that article away in a folder in the office and I think that's where I'll put Peter's letter too. No need to do anything more ... not just at the moment.

Doctor P
Well actually, I've had a PDP in place for just over a year now — I began it after a fascinating talk from some professor in Warwick where I was on a 'new things' course trying to catch a bit of extra PGEA.

What I really liked about it was the control — that and the flexibility. And the fact that I could relate it directly to patient care of course.

Not so keen on the pages and pages of tosh that came with the first draft that I saw though — no enthusiasm for listing my 'O'-level grades all over again! So I chucked that bit out and also the practice profile — couldn't see much point in involving the practice cleaner and part-time bereavement counsellor in my educational planning processes!

So what I've got now seems to work rather well I think and I don't mind if somebody wants to come and look at it to satisfy themselves that I'm an OK sort of doctor —

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2. Health Service Circular. [HSC 1999/154.] *Continuing Professional Development: Quality in The New NHS*. London: DoH, 1999.

so long as they don't start poking their nose in and telling me to do it all differently of course, or wasting my time with endless, touchy-feely questions!

Doctor A

Monday, 6.00 am

Bran Flakes, coffee, and journals. Read about PDPs. Brilliant! Take the randomness out of learning, keep the good and throw away the junk. Must find out something about Fragile X now that the Gibson boy's been given a diagnosis. And the diabetic clinic proforma needs updating — I could ask Miriam to do it, but it's probably quicker (and better) if I do it myself. And mustn't forget to put cardiology in the plan — it's a big subject, but a lot's been happening in cardiology since I left medical school!

Monday, 3.00 pm

Thinking about the PDP all morning. Shared my thoughts with the other partners, but they were somewhat lukewarm. Twenty minutes at the computer should be plenty of time to draft the paperwork I'll need — CV, Diary Sheets, Summary Sheets, Completed Objectives Register, Appraisal Forms, Feedback Forms, and Annual Return — and I think I'll get a yellow folder to keep it in.

Tuesday, 10.00 am

Couldn't wait for mail order, so popped in to WH Smith's on the way in to work and bought the folder. Have already made six Learning Needs entries and answered two of them over coffee ...

Three weeks later

Tried a new learning CD ROM on the surgery computer today. Sponsored by a consortium of drug companies but with independent editorial control from a reputable Dutch University department. Interesting question and answer sessions to assess your needs, interactive learning with good clinical cases, and a PGEA approved quiz at the end. Why waste time identifying your own learning needs when you can put yourself in the hands of the professionals?

James Heathcote

digest

in brief

The Edinburgh Festival, for all its riches, often fails to do the visual arts justice. Politicking between opposing factions of the Edinburgh arts establishment can lead the city's galleries to ignore the fact that the Festival is in town.

But not this year. At the **Scottish Gallery of Modern Art** there is a scatological Dali exhibition (until October) and, more importantly, a chance to see works from the Burgi Collection by Paul Klee — inventive, colourful, and witty in equal measure.

At the often overlooked **Scottish National Portrait Gallery** try to see *Men of the Clyde — Stanley Spencer's Vision of Port Glasgow* (until 1 October, thereafter back in their usual home at the Imperial War Museum, London).

The must-see exhibition is *Constable's Clouds* at the **National Gallery of Scotland** (until 29 October). Constable, better known for chocolate-box pastoral idylls, is here revealed as a pioneer of the skyscape. Rapidly executed oil studies of soaring cloud formations, marvellously lit, presaging Boudin and pre-Impressionism by a good 30 years. Particularly memorable are paintings of the Dorset coast, and of Hampstead Heath.

But enough of High Art — ***The Daily Telegraph*** (3 August 2000, page 27) continues to delight, particularly **'Letters to the Editor'**. As the Nation goes all curmudgeonly over the Dome ... **How many hospitals/community centres/police cars/frigates can one get for £1bn?** ... one Anthony Yannaghas gets straight to the point.

'Sir — Surely the nation should now start preparing to present the Queen Mother's daughter with a royal yacht for her Golden Jubilee in two years. How many yachts could we have built with the money that went into the Dome?"

How many indeed?

Alec Logan

False premises, false promises
Petr Skrabanek
Tarragon Press/The Skrabanek Foundation, June 2000.
HB, 236pp, £15, 1 87078111 2

For those who know the writing of Petr Skrabanek, this is a treat — but more importantly, it is a chance for new readers to make friends with one of the most individual and worthwhile voices to grace 20th century medicine.

I never met Petr Skrabanek, but his work and example was a strong influence. The writing was of genuine distinction. The prose was clean, muscular, with a propulsive thrust. The persona was witty and confident. Each essay was concise and beautifully structured. Almost all his writing was polemical, argumentative — slicing opponents with scalpel or machete as appropriate. The nearest parallel would be the American critic HL Mencken, whom he used to quote approvingly. But Skrabanek's essays were scholarly rather than journalistic, densely referenced in the central European academic tradition.

His personal example was important to me. Skrabanek epitomised an independence of spirit that was inspirational. Abruptly exiled from Czechoslovakia in 1968, he and his wife Vera had built a new and rich life in Dublin from the ground up. In the writing Skrabanek came across as fearless; reckless of whom he might offend. He seemed always to tell the truth as he saw it; in other words, he was a man of integrity. In this respect, in medicine, I can only think of one comparable figure who shared this quality — Sam Shuster, the Newcastle dermatologist. Both made plenty of enemies, as honest men will.

Skrabanek was a polymath — an all-round intellectual. He was a doctor and a scientist, he was steeped in European literature and philosophy. He particularly admired the French trio of Abelard (the medieval logician), Rabalais (the comic humanist) and Montaigne (the introspective essayist). Skrabanek moved and breathed easily in this world of high culture.

But Petr Skrabanek died prematurely in 1994 of aggressive prostate cancer, and his best work — in the essay form — was scattered across a multitude of journals. Over the years, I have collected the majority of the most important pieces into a box file which I treasure; but I had to acknowledge that few other readers would make the same effort. So this book is extremely important, since it collects a representative selection of the finest essays, and Skrabanek produced his best work in this form.

The essays are extremely well chosen (although strangely the editor is unnamed), and cover the broad sweep of Skrabanek's interests in medicine. Because he was a fundamentally serious (although not solemn) writer, literally everything Skrabanek wrote was worth reading. Given the constraints of space, it is therefore a shame that the volume opens with an overlong introductory essay which, although not bad, is considerably below the standard of the rest of the volume. The topics include breast cancer screening, acupuncture, electroconvulsive therapy, the discipline of epidemiology, preventive medicine, and an examination of the truth behind the oft-repeated story that nuns never get cervical cancer. There are philosophical essays on the nature of psychiatric illness, animal experimentation, and pseudoscience and a superb defence of the necessity of destructive criticism.

When one agrees with Skrabanek there is the satisfaction of seeing one's own views clarified and extended, and expressed with a tremendous rhetorical force comprising both logic and citation. When one disagrees, the same power hits you in the face. The experience is invigorating and profoundly challenging. Re-reading the psychiatric essays printed here, I recognised that, although I disagreed with them at the time they were published, they were in fact formative in shaping the new view of psychiatric diagnosis and treatment which I have recently published in a book. Alas, the book has appeared without this acknowledging this influence.

Skrabanek's perspective was rooted in science and rational thought. This may strike some people as shallow, or predictable. They would be mistaken. Skrabanek eschewed facile optimism and easy consolation. Indeed, his existential view is bleak, stoical, immensely courageous. He saw the fate of a man of reason as to 'die on the road' — never reach his goal, never see his cherished ideals achieved. So bleak, yet also tolerant. Like Rabelais and Montaigne, there is in these essays an embracing of imperfect, foolish humans as they are — not as we wish they were. There is a celebration of the consolations of life: food, drink, conversation, love. The logical, rational, scientific perspective was balanced, therefore, by an appreciation of vulgarity, vigour, and play.

Skrabanek's disdain was largely reserved for two groups. As someone who escaped from a totalitarian regime, he loathed the bureaucratic, the tyrannical; that coercive, controlling, puritanical morality which masks power. The life-denying elements. And he also hated the pseudoscientific — the people who used the tools of reason to defend unreason.

When he died he left a hole. There is no such figure on the contemporary scene. But then Skrabanek was one of a kind. He would surely not have been surprised by the downward path things have taken in medicine, the turn away from science and toward managerialism. As the NHS comes increasingly to resemble the seedy, corrupt and dishonest world of the Brezhnev era Eastern Bloc, I would have liked to hear his comments on the conversion of the rational

scepticism of clinical epidemiology to the irrational scepticism of evidence-based medicine. I would like to have heard his comments on the NICE, CHIMP, clinical governance and the rest of the menagerie of mediocrity.

But though I would have liked to hear his views, I could not predict them. No doubt he would have had something surprising to say — including something to make me uncomfortable, make me annoyed, make me think. This book reminds me how much I miss him.

Bruce Charlton

Clinical Judgement: evidence in practice
RS Downie, Jane Macnaughton
Oxford University Press, March 2000
PB, 196pp, £19.95, 0 19263216 7

I have learnt lasting truths from both these authors and, as a longstanding admirer, I bought their new book with high expectations but read it with an increasing sense of disappointment and frustration. At a time when the central place of clinical judgement seems in the process of being pushed aside by the false certainties of clinical guidelines, there is an urgent need for just this sort of exploration of the inevitability of the exercise of judgement within the clinical encounter. But, in the end, this book falls short.

From the start, the reader is confused by the authors' intentions. Who are they writing for? Some passages are extremely basic while others assume a considerable amount of prior knowledge; this is not a combination that works well. Most frustrating of all, the most difficult and challenging sequences in the analysis are glossed over. The case for the place of judgement is made convincingly, but when we come to the much more difficult issues of the nature and quality of judgement, how good judgement can be distinguished from bad judgement, and how the capacity for good judgement can be taught, this reader is left wanting much more.

Both writers are capable of beautiful prose and, while this flickers into life occasionally, much of the dry plodding style is reminiscent of an old-fashioned textbook. The mantra that a writer should tell us what he is going to tell us, then tell us, and then tell us what he's told us, is prosecuted to a point of serious tedium. At the end of each chapter the conclusions are presented as a series of minimalist bullet points that serve only to make the complicated appear simple; a process that is almost never helpful.

This summer, I read two books about clinical judgement. My good fortune was that much of my disappointment with the first was remedied by the second: a collection of the essays of Hans Georg Gadamer published in 1996 under the title of *The Enigma of Health: the art of healing in a scientific age* by Stanford University Press. Here, at last, is someone prepared to explore the task of medicine in relation to the major human questions, encompassing being and nothing, birth and death, good and evil. Gadamer offers no simple answers and deplores the 'reduction of truth to certainty'. Struggling every day with both the inevitability and the difficulty of clinical judgement, I find this profoundly reassuring.

Iona Heath

Refugees and Primary Care
Penny Trafford and Fedelma Winkler
RCGP, May 2000
PB, 68pp, £8.00, 0 85084258 1

With about 100 000 refugees arriving in the UK each year, GP practices may well be registering these patients on their list.

This little book is easily readable with clear, large print, short chapters, and useful tables. Yet it only scratches the surface of a topic which is still in its infancy in Britain. Turbulence in Europe and the Middle East will mean a constant flow of refugees to the UK.

The aim of the book is to paint a realistic picture of the daunting impact that a refugee group can have on a previously well established practice. It defines problems from a service user's and from a service provider's point of view, it demonstrates these problems using real scenarios from a sample of practices in London, and it extracts learning points that can be used to organise new services for the enhancement of any practice taking on refugees, and therefore ultimately meeting the needs of the refugees themselves.

I am a single-handed GP in the west end of Glasgow and I have recently been involved with refugees. My first experience was that of utter chaos, feeling frustrated at the poor communication and the sheer number of refugees attending at the same time.

I think this book is useful to any member of the primary health care team working with refugees. It does not attempt to give all the answers but helps to highlight the message that the initial sense of chaos and loss of control experienced by all practices can be replaced by a feeling of working in a well organised and satisfying situation. What is required most is plenty of good will, good practice organisation with discussion involving all members of the practice team, forward planning, and the enrolment of interpreters and other translating services. Making use of resources among the refugees themselves can also prove to be an invaluable asset.

This book will not only make readers aware that they are not alone in experiencing feelings of inadequacy but can also demonstrate ways in which services can be markedly improved.

Sandy Wirth

Big Brother
Channel 4 Television

Big Brother attracted phenomenal attention, (according to its enthusiastic but witless presenter), like 'Neil Armstrong stepping onto the moon'. Such impact is supposed to be old hat. Multi-channel television deprives us of any sense of shared experience, of watching the same programmes, communally. I have a vague, but fond recollection of a sweepstake in my undergraduate year about who shot JR Ewing. Television doesn't behave like that anymore, or so we're told.

But it does.

If the more intellectually prurient believe *Big Brother* was merely some plebeian tabloid event, the *Guardian* website has 3000 strings and commentary from *Guardian* writers and readers; the *Independent* 4000. The chattering classes are as involved as devotees of soaps and *The Sun.* There is analysis, not only from the usual 'rent-a-mouth' psychosocial commentators, but also from writers usually held in higher regard.

The show was neither sociology nor psychology, unless applied to the producers and viewers. The participants worked that out early on. 'It's only a game show!' they sang weekly during nominations. It's illegitimate to analyse the personalities of the housemates. Their circumstances were artificial and complex. The discovery of 'Nasty Nick's' duplicity and his confrontation with Craig was compelling, but Greek tragedy it wasn't.

What made the show was gossip. Gossip oils the wheels of human interaction. The production team knew this. In a virtual neighbourhood we shared opinions on people we felt we knew. Would Nick be sussed? Who'd have sex? (The British way — no one) Was the lovely — and likeable Anna making lesbianism mainstream? *Big Brother* was the currency of cappuccino bars, office water coolers and designated smoking areas. Sold as totally interactive TV, it wasn't. The residents weren't really interacting, or we with them. Really, we were interacting with each other and there's no harm, and potential good in that.

On winning, Craig told the ridiculously manic Davina McCall that he was donating the £70 000 prize to a relation with Down's syndrome to have a heart-lung transplant in the USA that the NHS would not consider. Now wouldn't it be nice if office gossip and media debate would concern itself with the various and complex issues around that girl's predicament?

Instead, expect more of the same. The phenomenon is international, and the demand for so-called 'real TV' shows no signs of abating. Give me 'real' *Eastenders* any day.

Stephen Hunter

Cum Scientia Caritas — or EBM?

Development of evidence-based medicine (EBM) is heralded as the way forward. There is an evangelical fervour to convert all doctors to the advantages of this 'explicit and judicious use of current best evidence in making decisions about the care of individual patients'.[1] But does this approach always achieve a cure? What of the role of the doctor as a therapeutic agent, once loosely called 'bedside manner'?

In the 1950s, a psychologist, Michael Balint — to some a prophet, to others the Messiah — viewed the doctor as a drug. He said, 'no pharmacology of this important drug exists yet. No guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and maintenance doses should be.' He went on to say that there is a lack of any literature on the possible hazards of this kind of 'medication', the various 'allergic' reactions an individual may encounter and any undesirable side-effects.[2]

Illness and disease are not synonymous and many ill people who consult a GP have no disease, but still have an illness that requires treatment. Thus, the application of EBM has severe limitations. Furthermore, it is usually based on randomised controlled trials (RCTs) in secondary care, where nearly all subjects have a disease and a different spectrum is seen. For example, only 10% of patients in primary care have the type of uncomplicated hypertension that can be managed by standard evidence-based guidelines.[3] So why not have primary care RCTs? Because of ethical and practical concerns, a GP providing continuous personal care to an individual patient may perceive or worry that they are exposing the patient to a medication that is inferior to current treatment. With this come difficulties with recruitment and randomisation. Imagine a double-blind RCT, where the GPs prescribing drugs to patients realise which drug they are giving, and if they do not fully believe in the new product then the outcome will be influenced, whether by verbal or non-verbal cues.

GPs have a dilemma, for they draw on two bodies of knowledge — that of secondary care-derived EBM and the insights of their individual experiences.[4] In addition, there is their unmeasured and unrealised therapeutic effect. Hence, their own knowledge, skills and attitudes (or feelings) may have a profound effect on both the process and the outcome of treatment and, in some cases, an effect greater than any evidence-based treatment. Whether or not a person has a disease or is considered to have a disease, they have an illness. Where appropriate reassurance is a powerful therapeutic tool that can lead to alleviation of an illness and associated symptoms, particularly where there is an absence of disease.

Without current best evidence, primary care will risk becoming rapidly out of date. But in practice, scientific evidence is only part of the knowledge required for a doctor to be effective. Knowledge of the individual patient is vital, as are their psychological, emotional, social and spiritual circumstances, and the recognition of their relevance to a particular illness is influenced by the knowledge, skills, and attitudes of the doctor giving treatment. When a patient is prescribed a treatment the patient actually receives two drugs: the one prescribed (evidence-based or not) to treat a defined disease condition and the doctor him or herself to treat the associated illness. The effect may be unpredictable, and might be seen as an interpretation of the Royal College of General Practitioners motto, *Cum scientia caritas*, translated as 'Scientific skill with loving-kindness.'[5]

The art of medicine is how to apply the science. This is not the mystique of the 'Church of Medicine', but the role of the 'good doctor'. Interestingly, politicians would do well to learn that there are almost enough resources to treat the population who have disease, but not illness. Tinkering and meddling with the primary care gatekeeper and associated primary health care team is likely to increase the inappropriate investigation and treatment of those who have illness, but not disease, and also threatens the cost-effective and therapeutic role of the jewel in the crown of a cash stretched NHS, the general practitioner.

Manish Latthe
Rodger Charlton

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e-*BJGP*
coming soon ...
work in progress ...

surinder singh

Medical Error — again?

How did it all start? Well, something like this. I responded to a very small advertisement in the back of a reputable medical journal last year asking for doctors who were 'willing to talk about a medical error' — fatal misjudgment, you may say, though I would say just idle curiosity.

Well, the next thing I remember is that I end up face to face with a friendly, approachable journalist talking about 'my particular error' in some coffee bar in outer Hampstead — yes, all very media-ish, I hear you say. It's a long story and before long you'll know all about it. It helped that I sent along a copy of the original personal view that was published in *BMA News*. The main journalistic questions were: was it true (yes), do I remember much about it (the nature of the event makes this an obvious yes), and would I be willing to go on TV to relate my story (unsure ... no — make that very unsure!).

I decided to think about it, even discuss it with various people; for example, my partners in practice and my medical defence organisation. I even thought about contacting the General Medical Council. This whole process took a long time but, for me, this was important since I became accustomed to what could be a traumatic event.

Finally, I agreed to be filmed, though this was after quite a lot of procrastination and endless conversations with the journalist. I even ended up doing my own research on the film company (it usually makes 'nature programmes' I was told at one point).

The filming was strange but functional. You know the type — the film crew come around to your surgery, you dress up like you've never dressed for surgery before, you pretend to be natural — while feeling totally alien to the whole process. I had asked our practice manager to be 'a patient', though she found the prospect of being on TV not unpleasant.

After the programme I was asked for advice about some of the accompanying reading material, and I've had a chance to see an early viewing of the programme — one that is 'pre-preview'. All I can say is that there are some very eminent people who are in the same 'I've-made-an-error' company and, thankfully, it is reassuring. Even the head of the GMC admits to making a mistake.

I have been going though my mind deciding about why I put myself through this angst — was it kudos, fame, or money? I'm really not sure it was any one of these. For those with a curious bent I received no fee during the whole exercise, though I was bought a cup of coffee in the hitherto mentioned coffee-shop and claimed for a taxi fare once. No, I think it has got to do with shifting the public's perception of the doctor to a position where omnipotence is replaced by openness, information-sharing, and realism. People make mistakes, doctors are people and so, by the application of simple reasoning, doctors make mistakes. That is not to say we should not do our hardest to prevent or minimise these errors. The public ought to realise that there is only so much a doctor — indeed any health professional — can do, that work is sometimes pressured and that, because of the nature of medicine, the foibles of those whom we see, and our own emotions, mistakes can happen. That in itself is worth discussing, though presumably this is why in the last six months 'medical error' has prompted a special issue of the *British Medical Journal* (18 March) and a whole conference. Undoubtedly, more is on its way.

But don't just watch the series because of this 'plug' — see it because you want to (it starts on Wednesday 4 October on Channel 4, for four consecutive weeks). If you ever have to do anything similar, you need to decide on your own motives and discuss it with lots of people — friends, relatives, partners, defence organisations. My big question remains: was the 'mistake' I confessed to really an error or did I just manage to see the patient early in the course of his illness and fate did the rest?

Dispatches from a five-ring circus ...

susan woldenberg butler

As a Games participant, I have the opportunity to realise my full potential. Focusing while those around you whinge is important. I tune out the allegations of corruption and elitism and tune in the endless Moments — those warm-fuzzy athletic profiles. And I'm so glad Sydney moved out the homeless and brought in purple and silver flowers. It makes me proud to belong to a nation that knows how to prioritise.

Being Tasmanian is a thing apart. Currently the mutton-bird gales (our equinoctial winds) are howling. No Olympic storms of protest whip our sheep-strewn paddocks, just the swell of bosoms heaving with pride of their Place in History. The torch passed through. Newspapers listed the name of every Tasmanian torchbearer.

But I must ignore distractions and practice my sports. Australian curmudgeons mumble about hunger in remote parts of the global village. Their soulmates call The Games a distraction from encroaching disaster and a mass opiate. Where can I get some? Does it show up in the urine or blood?

I practice my sports 14 hours a day. I'm part of something larger, so I'm giving it my best shot, and not with bow or put. My events are chewing and swallowing. I tell my worried mother than sprouting muscles are no reason to go to bed for a week, but she doesn't agree. Meanwhile, like others Down Under, I'm dreaming the Olympic dream and striving to be all that I can be. Every day in every way, I'm getting better and better.

colin butler

Even the top-rating eponymous satire didn't anticipate that Olympic medallions would feature the Roman Coliseum rather than a Greek temple, nor that senior government ministers would proclaim that to decline the $10 000-plus packages provided by big corporations would be negligent: so doing gives the Australian political elite an opportunity to hobnob with visiting dignitaries in order to make deals for the good of the Australian public. The press have been remarkably silent about this latest assault upon democracy. Are they too receiving special deals?

The erythropoietin policy penalises stupidity rather than chronic cheating. Urine tests reveal recent doping, blood tests more chronic exposure. Only evidence from both results in expulsion.

The Games, sandwiched between the US Open and whatever comes next, have been a wonderful distraction from ongoing Indonesian barbarism and our prime minister's refusal to apologise to East Timor (let alone to the first Australian inhabitants).

The hypocrisy is truly Olympian.

The respective roles of the RCGP President and Chairman

Introduction
Professor Dame Lesley Southgate, having been successful in the national ballot, will be elected President at the November 2000 AGM. Professor Mike Pringle will have, at that AGM, a further year of his three-year term as Chairman to run (subject to re-election by Council). This is an appropriate time to review and agree the respective roles of these two key College posts.

There is considerable scope for confusion. All other Royal Colleges elect a President who combines the roles of our President and Chairman. Naturally, therefore, those used to dealing with other Colleges tend to address all high level matters direct to our President. Even within our College there is sometimes confusion among Trustees and the membership concerning the two roles.

The division of responsibilities was decided on by the original steering committee that created the College's constitution, in recognition of the workload involved in representing the academic interests of such a large discipline and College. These reasons persist and there are no cogent arguments for adopting the presidential model of other Colleges. However, clarity in roles should help our system to work even more effectively.

The general division of roles
In general the President is the constitutional head of College and the Chairman is the executive head of the College. The President is elected by a ballot of the membership and is the conscience of the members. The Chairman is elected by Council and acts, through Council, in the interests of the College and its members.

The President acts as an ambassador for the College, its members, and the discipline of general practice; he ensures the integrity of 'membership' and 'fellowship'. The President chairs the general meetings of the College on behalf of the membership. In a constitutional crisis that Council or its officers cannot or will not resolve, the President has a duty to act on behalf of the membership to resolve that crisis.

While the membership through a general meeting (and subject to the approval of the Privy Council) is the final arbiter of the College's constitution within the College, the President has a role in ensuring the integrity of that process.

The Council is the policy-making body of the College and the Chairman is responsible to Council for informing the Trustees and acting on their behalf; developing policy, and representing policies agreed by Council; and the overall management of the College's affairs. College staff are ultimately accountable to the Chairman; the Chairman and officers work in partnership with the staff to deliver Council's policies.

Areas of potential confusion
The President, as an officer of the College and an experienced general practitioner, has a right and responsibility to contribute in private to the development of policy by the Chairman and other officers. However, policy is developed by or on behalf of the Chairman, and Council takes the ultimate decisions on policy issues. Since the President's main role is constitutional it is important that the President is not seen to take an overt role in policy decision-making or to disagree with established policy.

In committees, Council, and in public forums, the President should fulfil the constitutional role (most notably in the chairmanship of Fellowship and Awards committees); should support established College policies; and should represent the interests and philosophy of the discipline.

The Chairman has a responsibility to keep the President informed on important issues, including policy in development. The President has access to College papers and to College committees — such access is to ensure that the President is fully informed rather than to give the opportunity to lead or determine policy.

There may be areas of policy in which Council (or the Chairman and other officers on behalf of Council) request the President to take a more active role. In doing so it is important that this does not and is not perceived to undermine the constitutional position of the Presidency as 'sitting above policy'.

Inevitably, the President will be invited to and will attend events with a political content or context. In doing so, it is important that the Chairman is kept informed and that the President does not enter into discussions or communications concerning policy decisions. However, on such occasions the President should be able to represent the views of Council when appropriate.

Ways of working
The President and Chairman can only undertake their roles effectively by earning and retaining the respect and trust of Council and the membership. This, in turn, requires mutual respect for each other and clarity in their respective roles.

Arising from the above discussion, it is clear that the President and Chairman must be open with each other and must share all important information that each needs to undertake their roles. Where there is potential for confusion between roles this must be discussed and agreed, in advance if possible.

One practical issue concerns the handling of correspondence. Post for the President and Chairman should normally come through

GP Registrar Observer on UK Council

One of the two GP Registrar Observers on Council is due to stand down at the forthcoming AGM in November, having served her two-year term of office.

We are therefore looking to GP Registrars who are Associate Members of the College to stand for election and serve as an observer for the two years from November 2000 to November 2002.

Any GP Registrar who might be interested in standing should request a nomination form from Mike Whelan to be returned by no later than Friday 6 October. It is intended that the ballot will be held later in October and the result announced in the week before the AGM in order that the successful candidate can attend the first Council Meeting on Saturday 18 November.

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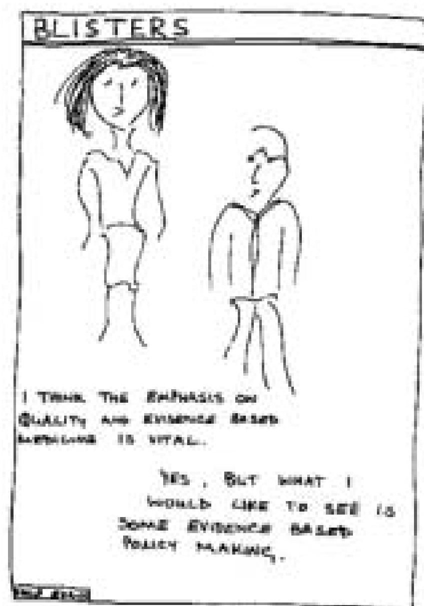
the College and be sorted by Corporate Affairs. Those letters concerning representing the College as an organisation in a non-political environment will be sent to the President for 'action' and copied to the Chairman for information. If originally addressed to the Chairman, he or she may acknowledge the letter, leaving the President to reply. Equally, letters concerning politics and policy will go to the Chairman to act, be copied to the President (if considered important to keep the President informed — the definition of 'important' should err on the side of inclusion) who may acknowledge the letter if it was originally addressed to them.

In other correspondence and communication, the President and Chairman will inter-refer when issues are within the area of responsibility of the other. Where there is genuine confusion (the topic appears to be both constitutional and executive, or there is lack of clarity) then the President and Chairman will discuss the right way to handle it.

Conclusion
The division of responsibilities for the President and the Chairman offers a considerable strength for the College, one that we are keen to protect and preserve. It does, however offer scope for some confusion and this document attempts to pre-empt that confusion.

Lesley Southgate
Mike Pringle



neville goodman

Reading

Enthusiasts for evidence-based medicine are fond of figures. Some of the most hard-line enthusiasts care only for figures; individual patients disappear in a welter of meta-analytic confidence limits dictating which drugs are given for what and when to give them. A favourite figure is the number of articles a doctor would have to read to keep up. It usually works out at something like 27 per day, including Sundays but allowing Christmas off. EBM, of course, simplifies this by reducing the mass of information to easy to follow meta-analytic algorithms — although the doctor also needs access to the Internet to catch up with the changes consequent on the 27 articles that appeared since yesterday.

This form of EBM, however, can be concerned only with clinical trials. Nowhere is mention made of the other reading doctors might want to do. I settled down in my office with a pile of unread journals. It took me a little over two hours to read what I wanted from two *BMJ*s and three *Lancet*s. I then read and took notes from a superb seven-page article by John Swales in the *Journal of the Royal Society of Medicine*.

Who can afford the time to do this? At the end of my nearly three-hour session, nothing that I had read or learned had any direct bearing whatever on my clinical practice. While the results of clinical trials can be amalgamated, there are many aspects of medicine that remain dependent on opinion and force of argument. There are no data that can be brought to bear. What are practitioners supposed to do? Should we ignore all articles not directly concerned with how to treat particular conditions? If so, who are these articles written for?

In the future, when we are all assessed on how well we remember the algorithms to cure diseases, and when we are tested every few years on our basic knowledge as well, we will have even less time to dwell on the less tangible aspects of what we do as doctors. When single-mindedly studying for exams, I steered well away from anything not in the syllabus that wouldn't or couldn't be tested, and faced with the risk of losing their livelihood that is what doctors will do. The very publicly conducted drive to ensure that doctors never make mistakes will not only fail, but will risk their losing touch with the humanity that is the most important part of medicine.

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Liam Farrell reserves his finest writing for the *Journal.* Dedicated Farrellists can inspect his cast-offs within the pages of *Doctor,* the *BMJ*, and lesser publications
Iona Heath has at least 88 entries in *PubMed* at the latest count. She chairs the RCGP Inequality Working Group from which potent arguments will emerge in 2001
John Howie retires from the world's first chair of general practice, in Edinburgh, this month. We wish him well
Stephen Hunter is the medical director of a Welsh acute trust. His most inventive contribution to the *Big Brother* website was to invite members of the GPC to model BMA House from chicken tandoori masala.
Manish Latthe is a GP Principal at the Tower Hill Medical Centre, Great Barr, Birmingham
Dorothy Logie is a 'referrals adviser' to Borders Health Board, but, again, *PubMed* supplies the juicier details
Mike Pringle is professor of general Practice at Nottingham, and chairs UK Council. He regularly pops round to Downing Street for sushi and babysitting
Blair Smith has recently been elevated to senior lecturership in the department of general practice, Aberdeen
Dame **Lesley Southgate** assumes the Presidency of the RCGP in November
Anna Wilson is a GP in Sutton Scotney, Hampshire and former Chair of the Wessex Faculty RCGP
Sandy Wirth is originally from Malta. She graduated from Glasgow in 1982, and still works there, in Whiteinch, as a single-handed principal
Sally Wyke is Foundation Director of the Scottish School of Primary Care, at **www.sspc.uk.com/**

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liam farrell

Now that I don't travel by Concorde anymore, my second career as a media superstar requires a lot of driving, and I have found that nothing shortens the journey like a good audio-book. Get involved and the time flies, you'll nearly be sorry you've arrived. My tastes are eclectic, from Dickens to *The X-Files*, from Anthony Trollope to Michael Crichton, but most of all I recommend the slow mid-western drawl of Garrison Kiellor. His essays about the mythical town of Lake Wobegon in Minnesota are at the same time soothing and stimulating, comic and philosophic. Lake Wobegon, he tells us, was settled over a hundred years ago by a group of immigrant Norwegian farmers, and their descendants are, as Kiellor observes with the occasional trace of affection, a dour people of very few words.

I can sympathise; during my years of general practice I have come to share some of these Norwegian virtues, as I am increasingly suspicious of people who are too happy-go-lucky (I'm not happy, I'm not lucky, and I don't go). They either know something I don't or they are repressing and ready to explode.

A patient of mine is a folk-singer, and accordingly manifests both the irritating tweeness and the indefatigable optimism demanded by the accursed breed. I reckon it's mainly due to all those years of being dandled on his granny's knee; at forty-two he's a bit old to be still at it, but the old lady remains hale and hearty and by now has thigh muscles so well developed they could crack walnuts.

Nothing seems to get him down and his cheerfulness is almost pathological. Lashing rain is a 'soft day, thank God'; something bad happening merits: 'If that's the worst thing that happens to us today, we've had a good day'; something *really* bad happening earns: 'At least I'm not Scottish'. I imagine telling him some day, 'Tadgh, I have some bad news for you. It's about your dog, the one you sat up all night delivering and who has been your inseparable companion and only consolation since your wife passed away so tragically all those years ago and who only last week saved your father from being asphyxiated by a rancid peccary; I regret to say I've just run her down and she is beyond resuscitation on account of you normally needing your head not being squashed for that to work.'

He'd be silent for a while, maybe a little sob for theatrical purposes, then look up at me with a twinkle in his eyes (you can't learn that twinkle, and surgical attempts to recreate it have only ended up with an evil squint) and a plucky smile and say, 'You know, Doc, when I was just a wee lad my grand-daddy used to sing a song about that while he was teaching me how to scratch my eyeballs with a fork', and he'd close his eyes, switching off the twinkle for a moment, and start to croon in a voice that was full of anguish, pain, and sorrow but yet strangely also full of joy and wonder and bestiality (his emotions were a little mixed up, you may gather) and a hope for a new tomorrow that maybe would also bring a new dog:

> 'The driver ran over my dog', he'd lilt,
> 'It was the driver's door that caught her,
> But every cloud has a silver lining
> He reversed over Harry Potter,
> Toor-aloor-a-loora'

Simultaneously laughing and crying he'd hug me close to his suspiciously quivering bosom, and whisper, 'By the way, I have to kill you now,' the sun glinting merrily on the carving-knife. It's like when Frankenstein was happy, playing with the little girl; it was not a good time to go near him with a torch. 'Mirth is always good and cannot be excessive', said Spinoza, but as Garrison Kiellor's Norwegian farmers might retort, what would he know about it?

Dedicated to my good friend Tommy Sands, who does not own a dog.