The British Journal of General Practice

Viewpoint

General practice, primary care, and general practitioners

At a recent meeting I ventured to say that 'general practice is dead — long live primary care'. This did not go down well with everyone in the group: general practice certainly was not dead, they felt, and I was misguided. Who was right? The nature of general practice has certainly changed but in my opinion the biggest changes are yet to come.

We are comfortable with working in primary care teams, with team members from different professions, with different employers coming, sometimes, from outside the NHS. If we are happy with this model of teams then what is general practice compared with primary care? Practices run as small businesses by general practitioners (or by practice managers) have been very successful. They have balanced the needs of their patients with those of the population they care for. They fulfilled a public health role (through, for instance, immunisations) while still caring for the individual. This balance was put to the test with the advent of fundholding, with many predicting that the relationship between patient and doctor would be ruined — the needs of the fund, and hence broader population, subsuming the need of the individual. However, this did not happen in most instances and the separation between general practice as a purchaser organisation and the general practitioner as a provider of care was maintained. Nevertheless, the role for the practice seems set to change.

Many of us embraced co-operatives with enthusiasm, handing over this aspect of care to an organisation that covered many practices in a geographical area. This seemed to provide fertile ground for the formation of PCGs, and now PCTs. With a few exceptions, we are coming together within these new primary care organisations to deliver care across an area. There appears to be a large degree of interest in personal medical services (PMS), the government's preferred model for general practitioner contracts.[1] Although these will be practice-based contracts it is likely that in most instances the employer will be the PCT and that the contract will be largely PCT-wide, with little variation between practices. In addition, PCGs will be providing some secondary services (through PMS+ or the GP specialist — an oxymoron if ever there was). This is surely a change from how care is currently organised within practices. So, as general practitioners we appear to be moving from solely being part of a practice to also being part of a larger organisation. We are beginning to feel what it is like to be part of a corporation with corporate and clinical governance developing hand in hand. It is not so clear who in the future will employ staff currently employed by practice; I suspect that over the next few years many more will be employed by a PCT directly, perhaps starting with practice nurses who will want parity with their district nursing and health visitor colleagues. It is less clear what will happen to the ownership of premises and other aspects of the small business that characterises general practice.

There comes an obvious warning with these predictions. What we have now is pretty good;[2] it has delivered high quality care in severely constrained circumstances.[3] What has worked best is the independent and flexible working of primary care teams and this must not be lost. Furthermore, GPs have given continuous care to their patients — an important component of a quality service. Primary care teams are flexible, self-organising units that usually provide good care in a complex world. General practice has not always delivered good care in terms of following guidelines or best practice. Practices do not always provide adequate access. I think that as we start to work in larger organisations we might be able to improve these systematic aspects of care. Whether a patient is receiving aspirin after their myocardial infarction might best be achieved by a quality assurance system organised at PCT level. Where does the general practitioner fit into this? Doing what we do best, caring for patients at an interpersonal level, considering the psychosocial context of their illness, and steering them through the complex world of health care.[4] This is where our strength lies and for the patient's sake we must ensure we are there providing this service for them. Unfortunately, this aspect of care is less easily measured than the systematic care described above, it does not fit so well onto a league table. It is our duty to make sure it is not lost.

So, even if the general practitioner has a role, the future for general practice is far from certain in my mind. The way in which we work as primary care teams and in new primary care organisations with new contracts are replacing general practice.

Tim Wilson

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The Back Pages...

"Everything went out of my mind — the little girl was so beautiful ... The way they used to paint angels. But there was a strange cloudiness in the depth of her eyes: it was terror — she couldn't breathe. 'She'll be dead within the hour,' I thought, absolutely sure of my facts, and felt my heart lurch in alarm ..."

from *The Steel Windpipe*
by **Mikhail Bulgakov**
pp 1022

contents

The goddess of recovery

Of 180 listed on a website of healing gods and goddesses,[1] only the greek goddess Iaso included 'recovery' in her powers. Iaso, a daughter of Aesclepius, was sister of Hygeia and Panacea, the better known goddesses of health and cure. As GPs, our mission to make and keep our patients well uniquely places us to witness their whole recovery, especially when this follows a complex illness or is complicated by conflicting social, economic or occupational factors. These can delay a return to adult psychological responses from those of the dependent child,[2] and the dilemma facing the GP in encouraging recovery is especially apparent in sickness certification.[3] As patient advocates, we license absence from work, yet this may ultimately impair return to healthy independence. Return to work demands may place additional strain upon a complex web of newly developed economic and social dependencies, such as child or elder caring responsibilities.

Although return to economic self-sufficiency may seem a great hurdle, long-term dependency on benefits, by definition, restricts full recovery of the individual and unemployment is itself unhealthy.[4] GPs are well aware of these constraints, for the relative prosperity of the patient and his family may subsequently depend on deteriorating independence triggering additional benefits such as better housing or a subsidised car, these generally requiring a GPs' testament. Individuals locked into inactivity by medical certificates cannot share in cyclically enhanced local economic opportunities. Such perverse incentives also handicap the economy as globalisation encourages companies to move work away from countries where incentive is undermined by corporate or individual taxation.[5]

Until recently, there was little a GP could do to enable a patient who might otherwise slip into such downward spirals. Rehabilitation services, generally thin on the ground, were prioritised towards mobilising those more severely disabled patients requiring help with daily living. However, a 'New Deal' initiative announced in the budget will fund testing health care and workplace interventions at six weeks of incapacity, including mental health. Possible interventions to keep people in work or get them back there quickly include early access to evidence-based talking or physical therapies, enhanced access to hospital referral, or formal rehabilitation programmes, and workplace changes such as adaptations, design, training, and mentoring. The Initiative is run from the Department for Education and Employment in partnership with the Departments of Social Security and Health. Details from: Job Retention Initiative, Room N809, DfEE, Moorfoot, Sheffield S1 4PQ. Tel 01142591016.

Jim Ford

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Eric Gambrill Memorial Fund

Applications are invited for two travelling fellowships, each worth £2000, to be awarded in April 2001. Those eligible for the awards should be fully trained and practising general medical practitioners.

In recognition of Dr Eric Gambrill's interest in general practice, education and travel, the successful applicants will be expected to undertake a study or project as part of their professional career development.

The closing date for the receipt of applications is **25 March 2001**. Application forms and further information may be obtained from: The Secretary to the Trustees, Eric Gambrill Memorial Fund, 2 Stirling House, Stirling Road, Guildford, Surrey GU2 5RF; tel 01483 579492.

Sailing to a better understanding

At least once a year I leave my general practice where I am a principal, pack my bags, and join the *Lord Nelson* — a three-masted barque with square sails on the first two masts. The *Lord Nelson* and her sister ship, the *Tenacious* (due to be launched this month (God bless the lottery and its good causes!), are designed with both able-bodied and the disabled in mind. The *Lord Nelson* sails around the coast of Britain in the summer and 'island hops' around the Canaries in the winter; its trips last about a week.

I am considerably disabled from MS and while on board use a wheelchair (walking on two sticks when the ship heels over is not a good option!). The disabilities endured by some of those on board vary considerably, from cerebral palsy and spine and brain injuries to the totally blind, who steer the ship with the aid of a 'talking compass' device. I never cease to be amazed by the blind who, after being led around the ship just once by a member of the crew, negotiate the stairways and decks with ease. The disabled crew take part in all the activities on the ship from hauling on ropes to the watches and galley duty, but are spared sail handling out on the yards.

Although everybody has a good holiday — we have barbeques on the stern platform or go for a swim in the warm waters of the Canaries — there is in fact a serious purpose to the trip. Whereas the disabled gain confidence in their own abilities, and learn to mix with a wide variety of people (I can remember cleaning the heads in the company of a barrister) the able-bodied learn about disabled people: when to offer help and when to leave us to struggle. It is a learning experience for the able-bodied; having to rely upon as well as to help the disabled is a salutary experience. The changes that take place in some people in just a week is both surprising and impressive. The permanent crew, though, have seen it all before and all of them from the cook to the captain help everyone to perform to their full potential.

There is a doctor on board and he or she is usually a GP, but I have sailed with doctors disabled or otherwise from many branches of medicine. The doctor has a significantly reduced voyage fee. Anybody who is interested may apply to: Jubilee Sailing Trust Ltd, Jubilee Yard, Hazel Road, Woolston, Southampton SO19 7GB; tel 02380 44 9108; fax 02380 44 9145

Richard A Hayward

Letters from the Tibetan Refugee Hospital, Dharamsala, North India

I'm getting quite churned up now about going away — one minute I'm excited the next I'm petrified, but overall I'm thrilled to have this opportunity to work somewhere as beautiful as Dharamsala.

A Tibetan woman delivered a 4.25 kg girl last night, requiring the biggest episiotomy I've ever seen. The delivery itself was uneventful, but it took forever for everything to get back into place — well sort of into place! I'm going off the idea of ever having children; adoption sounds good.

Giardia, O Giardia,
Rumbling in my belly,
Giardia, O Giardia,
You make my farts smelly.

You make my stools loose,
They reach grade 4 and more,
You instil such cramps and urgency,
As I've never felt before.

I'm not the worst sufferer though,
(You're mean enough to me)
My fellow toilet sharers
Are cursing outwardly…

The breadth of the work here is quite amazing and very challenging. We had a Swiss psychotic who thought he was Jesus a couple of weeks ago, who was flown back to Geneva. Last night I admitted the sorriest looking Tibetan I've ever seen — a 25-year-old man who was so emaciated I could hardly believe that he was still alive. I'm pretty hardened I think about most things, but I found myself in tears today. It often makes me wonder: why am I here?

His Holiness's brother, Tenzin Choegyal, gave a talk in the hospital yesterday on anger management, which was fascinating and quite challenging. People here truly live out their faith in a practical way, all week long — not just on Sunday, which is very refreshing to see.

The monsoon has well and truly lost its grip and the Indian summer is beautiful. We've had a few balmy dinners on the balcony, and it's lovely in the mornings as well. I've been pottering around Dharamsala, and there are still many things I'd like to see before I go. My three months here has been the richest learning experience of my life so far.

Wendy Muircroft

At the time of going to press there is a vacancy at the Tibetan Hospital for one volunteer, starting immediately, until the end of March at least. Contact Delek Hospital (e-mail address: **delek@nde.vsnl.net.in**). *To volunteer at a future date contact Alan Munro at* **alan.munro@virgin.net** *or at Guisachan, Black Isle Rd, Muir of Ord, Ross-shire, IV6 7RR*

blair smith

The do-it-yourself guide to designing your own CV

I have had several occasions recently both to compose my own CV and to appraise those of others. As far as I am aware, this has nothing to do either with impending redundancy or with expansion of my empire, though the academic world often teeters on the edge of such instabilities. Being a member of the RCGP, it is, of course, impossible for me to conduct such activities without simultaneous reflection on the processes, and through this I have identified several features common to a 'good' CV.

An academic CV should paint a portrait of an ambitious, high-achiever with a widely-respected intellect, capable of setting the world (or at least the coffee room) ablaze, and leaving competitors gasping in awe (Competitors? Did I really write that? I mean, of course, colleagues with a mutual interest). Given, therefore, that academics are naturally diffident, humble individuals who merely hope to contribute to the body of human knowledge, how are we to address this paradox? These hints are the result of reflection and focus group discussion.

1. **Leave nothing out** — the primary principle. Every detail is important, and even the banal can be spun into the commendable.

2. **Speak Latin**. It's not, after all a CV, but *curriculum vitae*. Appropriate display of classical education still impresses, even in this technological age.

3. **Your name**. As early as possible in your career, change this to something memorable and distinguished. This step alone will convert the mediocre career into a comet trip. Use of hyphens and double barrels is particularly to be encouraged, as is the adoption of forenames such as Marshall, Mac, Bonnie or Leo. Someone called Somerset Maugham, for instance, was destined for dizzy heights the minute he was baptized, and it wasn't until the composer Joe Green changed his name to the Italian version that his opera career took off.

4. **Publications**. This is the most important part. Academics love seeing their name in print, and value this in others more than anything. Therefore, begin early to build your catalogue. Be imaginative. Write, for example, to the *Daily Telegraph* with your views on the Queen Mother, and include this in the 'Correspondence (submitted)' section. Look for journals you've never heard of and send them any old crap. Write a feature for the *BJGP*. It all counts, and there is nothing more impressive than a long list. Above all, title this section of your CV 'Selected Publications', creating both the impression of an iceberg tip and the influence of an important mentor.

5. **Outside Interests**. This is a tricky one, finely balanced in judging the expectations of the reader. Part of you wants to demonstrate that your ambition spills over into all walks of life. This part is keen to highlight your runner-up medal in the badminton club over-35s competition. It may also describe your assistant coaching of the Cubs 5-a-side team (which really does very well despite the high prevalence of special needs). Yet, on the other hand, you are so dedicated to your work that that you don't have time for trivia, such as the rest of life. On balance, it's probably best to have a few declared interests, but to make these overtly academic (eg School Board, Children's Panel, Village Epidemiological Society).

6. **Career Plan**. This is an easy section to write, as it should simply be a regurgitation of the job advert. It helps if you can drop a few prominent names too.

7. **Family**. Don't have one.

These techniques, made public here for the first time, have helped many professors into many posts. With practice and time, there is no reason why you, too, may not be shortlisted with the best of them. After that comes the hard part — doing the job.

Postcards from a New Century

A new GP for a new society?

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

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What are GPs for ?

For many GPs the answer to the question 'what are you there for?' seems axiomatic. However, a moment''s reflection on the potentially competing roles of a less familiar occupational group reveals how influential the choice of a 'mission statement' can be. Consider the London Fire Brigade. If we define their purpose as 'putting our fires' this leads to a certain set of priorities and activities. Alternatively, if its mission is 'preventing fires' this changes the emphasis and has implications for recruitment, training, and deployment. A similar debate about identity and function is, arguably, the most important issue facing general practice today.

The context in which we ask this question

Introspection by professionals about their role, is just one manifestation of a phenomenon that Francis Fukuyama calls 'The Great Disruption'.[1] His analysis is important because it provides a framework into which issues like the changing role of professions and other issues that concern doctors (for example, increasing inequalities)[2] are seen to be manifestations of a more profound, but analysable, pattern of change. Fukuyama shows how, in the past half century, North America, Europe and parts of Asia have undergone a transition to become post-industrial societies in which service industries replace manufacturing and a new 'knowledge economy' is emerging.[3] In this new globalised world, consumer choice explodes and large rigid bureaucracies find it impossible to control everything in their domain through rules, regulations, and coercion. The period that has seen this transformation (from the mid-1960s till the present) has also witnessed profound social change. Crime and social disorder have risen while kinship as a social institution has accelerated its long decline. Fertility rates have fallen, divorce has soared while out-of-marriage childbearing has increased. Perhaps most important of all, trust and confidence in institutions have declined. Within local communities, mutual ties between people have tended to become weaker and less permanent. Many of these changes can be seen, at least in part, as beneficial but their combined effects have been traumatic to large sections of society.[4]

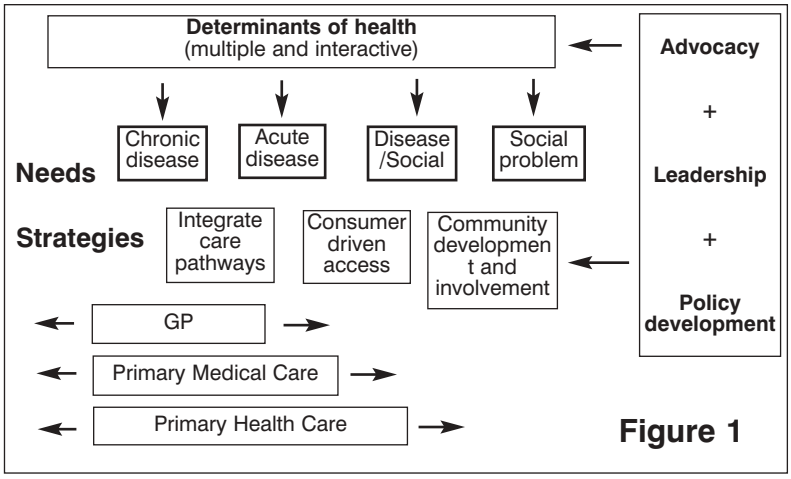

Figure 1

What caused the great disruption?

Politicians of the left have tended to blame a lack of adequate welfare provision and increasing poverty for the great disruption while others argue that post war social problems have been caused by too much wealth leading to growing individualism. Ill-conceived government policies have also come under the spotlight but none of these analyses fully explain the great disruption because similar trends have occurred under such a wide variety of political systems. Rather, we have to look to a set of demographic, economic and cultural changes that have changed the nature of work, the respective roles of men and women and altered many fundamentals of life (including the family, leisure, beliefs, values and norms). For example, the increase in life expectancy and greater control of fertility made it both inevitable and desirable that women should seek a wider range of activities beyond their traditional child-rearing and home-making roles. Simultaneously, the new knowledge-based economy had less use for the physical strength of young men. The result in some communities is a large cohort of younger men who find themselves without a meaningful role at home or in work and many of them lack the education or social skills to remedy the situation. Could this be the explanation for the fact that younger men have seen an absolute increase in their death rates in recent years mostly through accidents, suicide, drug-related deaths and violence?[5]

The great disruption and its effect on patients

These changes have profound implications for health. For example, as the whole world moves towards a single market in labour and skills, all economies may experience a widening of incomes ranging from the highly paid (but time poor) knowledge workers down to unskilled workers in the manufacturing and service sectors who may have to accept 'third world' wages, or risk losing their jobs to international competition. Economies may be under pressure to deregulate to reduce costs and increase 'flexibility' or risk losing investment to other parts of the world economy. The result may be greater inequalities in wealth and health within individual countries like the UK.

If, as Richard Winkinson argues,[6] the distribution of wealth is a more important determinant of health in a developed nation than the gross national product, the scenario painted above has important implications for health. The question that now arises is: what coherent vision of the future can be offered by public health advocates if the powerful, perhaps irresistible, engine of the global economy is going to create greater income inequality and greater deregulation.

There is, of course, a more optimistic scenario for the future (of which more later) but, for the

moment, it is important to recognise the potential of forces that may threaten the well being of the populations and patients we serve.

Back to the question — what are GPs for?
How should GPs respond to this set of changes? This series (Postcards from a New Century) has successfully highlighted the multiplicity of functions a GP might be expected to fulfil. Paul Hodgkin observed that patients (while in consumer mode) want 'fast, efficient courteous service from professionals who are competent'. At the same time, patients with established chronic diseases require the creation of a 'well-run oasis of systematic care'. Nick Summerton used the symptom pyramid to illustrate why GPs must be skilled in recognising normality so that they can act as gate keepers to the rest of the health care system. Glyn Elwyn highlighted the role of GPs in interpreting and communicating risk. This list seems daunting enough but there are yet more important demands to be made of GPs in the 21st century.

The challenge of whole person medicine
A further challenge for GPs is the need to take account of the impact of personal factors such as stress, emotional trauma, grief and loneliness on organic disease. The problems are that current approaches too often miss out a mind-body perspective, delivery can be rushed, and treatment is overly dependent on drugs. Patients and GPs complain that fragmentation is occurring with too many specialists seeing the one patient and not enough 'glue' in the centre of care management to keep things together. The re-assertion of a generalist, holistic perspective is required.

Improving health in whole communities
Primary care could make a larger impact on the health of local populations. How health is promoted or destroyed in communities is now well understood. Health emerges from a complex interaction between genetic inheritance, the physical circumstances in which people grow up and live (housing, air quality, working environment), the social environment (levels of friendship, support and trust), personal behaviour (smoking, diet, exercise) and, crucially, access to, or lack of, money and other resources that give control over life. These influences operate in a complex and interactive manner to create or destroy health.[7-9]

It is also now well understood that these complex and interactive determinants of health operate over the whole life span.[10] Maternal deprivation can affect birth weight and create influences that will manifest themselves years later as chronic disease in middle age. Habits, skills, and behaviours acquired during childhood have a profound influence on educational outcomes, job prospects, and levels of disease.

Unfortunately, public and media debate about health is often narrowly confined to health service issues — the local hospital threatened with closure, the child refused costly treatment for an inevitably fatal condition — and so the short-term urgent becomes the enemy of the longer-term important. General practitioners can either collude with this distorted view or join in a wider process of advocacy and community development to improve health by truly confronting the wider determinants of health. Individuals such as Julian Tudor Hart[11] have pioneered this approach but it is not yet in the mainstream of UK general practice.

Defining the scope of primary care
Given the range and diversity of challenges that could be taken up by general practitioners, the task of defining the scope of primary care is not just of academic interest. Primary care potentially encompasses all of the above challenges and Figure 1 illustrates the relationship between different types of needs and strategies and the scope of primary care.[12]

This model places the actions and efforts of individuals, families, and communities at the heart of primary care supported by a large number of professionals: doctors, nurses, pharmacists, dentists, chiropodists, physio-therapists, etc. These are in turn working in partnership with an even larger range of people, organisations and institutions that have an impact upon health and well being.

The implications of this breadth of activity are wide reaching. It requires primary care practitioners and organisations to work with a large number of partners as part of a co-ordinated effort to improve health in defined communities. This style of work will require primary care teams to learn some new skills, balance competing priorities and work more with communities (while maintaining their established contact with individuals and families). Clearly, the primary care team will seek to utilise the contributions of many different disciplines but it will probably also work in a variety of locations (beyond the traditional surgery and patient's home).

In short, an expanded concept of the primary care team could confront all the challenges set out in the preceding paragraphs. Will all GPs feel equally happy with the breadth of this agenda? Probably not, but it does reflect the scope of the challenge. Provided the fast developing primary care organisations north and south of the border embrace this wider vision, individual doctors should be able to play to their personal strengths within effective teams. Some might major on population strategies while others work more will individuals on the 'whole person' challenges. All will be generalists but the diversities in emphasis will increase. A consequence of these changes is that, as other professional groups diversity their roles and gain in confidence, this might spell the end of automatic medical dominance (no bad thing, perhaps?).

A new society?
Great disruptions in history are not new. At the beginning of the industrial revolution alcohol consumption, crime, and illegitimacy were substantially higher in most UK and American cities than they are today.[1] What emerged in that period was a reaction to the social disorder that accompanied the upheavals brought about by the industrial revolution. Victorian society deliberately sought to create institutions and instil values that would create order out of what seemed like chaos. Thus, in time, emerged co-operative societies, modern police forces, health visitors, universal education, orphanages and much else. These were supported by grass roots efforts to create and sustain a whole series of informal norms and behaviours that in their time were important for social order. The fact that these eventually became outmoded and now often seem illiberal to our modern eyes does not mean that they were not radical in their time.

Human societies have been very inventive and successful in their response to change. Can we be as successful in our responses to a post-modern and post-industrial society? The lesson of history is that we should be optimistic.

A new kind of doctor?
We can create a new society that takes the best from globalisation while confronting or mitigating its worst effects? We can fashion new institutions (including primary care organisations) that are broad enough in their vision to respond to this complexity? Will a new style of GP emerge from this maelstrom?

Phil Hanlon

Risky business

The NHS is a gigantic risk-sharing enterprise — I get MS and you bear the costs of my medical care till I die. But what happens as genetic testing renders the risk of MS predictable? For insurers, testing means that those at higher risk should pay more. Such discrimination has led Austria to ban private health insurers using genetic tests. However someone who tests positive then has a strong incentive to buy insurance — banning genetic testing from insurance assessments simply concentrates high risk clients in the insured pool. Hence the UK's recent decision to allow insurers access to a limited range of tests.

It seems private health insurance is only profitable when genetic risks are unknowable. This dilemma does not arise for governments who have a genuine interest in the health of all citizens. Genetic testing may prove a poisoned chalice for private insurance but it is a compelling reason for state financed universal health care. Good old Auntie NHS was right all along!

The Economist October 21st 2000

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The Steel Windpipe

Then one night I was alone. Everything was engulfed in a pitch black November night, the snow freaking down and shrouding the house, the chimneys howling. I had spent all twenty-four years of my life in a sprawling city, and thought that blizzards howled only in novels. Now I knew they howled in real life. Evenings here were interminably long. I would stare at the gleam of the lamp with its dark blue shade reflecting on the window and dream dreams. I dreamed of the district centre. It was about 25 miles away. I longed to run off there, and abandon my medical outpost. They had electricity, and four doctors I could ask for advice; it would certainly be less terrifying than here. But there was no chance of running away, and from time to time I realised it would be spineless. This was what I had studied medicine for, after all.

But what if they were to bring in a woman in complicated labour? Or someone with an incarcerated hernia? What would I do then? Please advise. Forty-eight days ago I had graduated *cum laude*. But *cum laude* is one thing, and a hernia is another. Once I had watched a professor operate on an incarcerated hernia. He operated, I sat in the amphitheatre. That was the long and short of it.

A cold sweat would run down my spine at the mere thought of a hernia. Every evening I sat in the same posture, drinking one cup of tea after the other. By my left hand were all my practical obstetrics books, with a pocket Doderlein on top. On my right were 10 different volumes on operative surgery, with diagrams. I griped and groaned, smoked, and drank cold black tea.

Once I fell asleep. I remember the night quite vividly — it was 29 November. I woke up to the sound of hammering on the door. Five minutes later I was pulling on my trousers, my eyes fixed imploringly on the holy writ of operative surgery. I could hear a sledge scrape across the yard: my hearing had become exceptionally acute. It turned out, if anything, to be more terrifying than a hernia or a breech delivery. At 11 o'clock at night someone was bringing a little girl to the Nikolsky medical outpost. The woman with her said tonelessly: 'The little girl's weak. She's dying. Please, doctor, admit her to the hospital.'

I recall crossing the yard towards the doorway of the cottage hospital, mesmerised by the flickering of the paraffin lamp. The lights were already on in the surgery and my staff were waiting for me, dressed and in their gowns. They were Demyan Lukich, my assistant, who was young but very capable, and two experienced midwives: Anna Nikolaevna and Pelageya Ivanovna. And I myself, 24 years old, two months out of university and in charge of the Nikolsky medical outpost.

The assistant solemnly opened the doors and the mother appeared — or rather she flew into the room, slithering in her boots, the snow still beaded and frozen on her headscarf. In her arms she held a bundle that quietly wheezed and whistled. The mother's face was twisted and she was sobbing noiselessly. When she threw off her coat and shawl and unbound her bundle, I saw a little girl of about three. I looked at her and for the moment forgot about operative surgery, my isolation, my wholly inadequate university training. Everything went out of my mind — the little girl was so beautiful. What could I compare her with? You see children like her only on chocolate boxes — hair in natural rings and curls the colour of ripe barley, huge dark blue eyes, cheeks like a porcelain doll. The way they used to paint angels. But there was a strange cloudiness in the depth of her eyes: it was terror — she couldn't breathe. 'She'll be dead within the hour,' I thought, absolutely sure of my facts, and felt my heart lurch in alarm.

Tiny recesses appeared in the girl's throat every time she breathed in. Her veins were distended and her face was turning from pink to a pale lilac. I realised straightaway what her colouring meant. I made my first diagnosis: not only was it correct but, more importantly, I voiced it as rapidly as the midwives' with all their years of experience. 'The little girl's got diphtherial croup. Her throat's chockful of membrane and about to close over'. 'How long has she been ill?' I asked. My staff were tense and silent. 'This is the fifth day. The fifth,' the mother said, her dry eyes probing me. 'Diphtheria,' I said to my assistant under my breath, but then buttonholed the mother: 'What on earth were you thinking about? Why have you left it so long?' Then I heard a weepy voice behind me:

'Five days, sir, five days!' I turned round and saw a moon-faced old woman in a headscarf who had been standing quietly there. 'I'd like to see the back of you,' I thought to myself. With a sickening presentiment of bad news to come, I said: 'Shush, woman, you're only in the way,' and again asked the mother: 'Why did you leave it so long? Five days? What were you thinking about?'

"The woman with her said tonelessly: 'The little girl's weak. She's dying. Please, doctor, admit her to the hospital.'"

Suddenly, the mother handed the girl to the old woman with a practised movement and sank to her knees before me. 'Give her some drops!' she implored and touched the floor with her forehead. 'I'll hang myself if she dies.' 'Get up this minute,' I replied, 'or I won't even talk to you.'

The mother stood up quickly, flounced out her wide skirt, took the girl back from the old woman and began rocking her. The old woman turned to the window frame and began praying, and the little girl breathed, still hissing like a snake. My assistant said 'That's what they all do. The salt of the earth.' His moustache twisted as he spoke. 'Does that mean she's going to die then?' the mother asked, staring at me with what I took to be black fury. 'Yes, she's going to die,' I said quietly but firmly. 'Help her! Give her some medicine! Some medicine!' I could see what was in store for me, but held my ground. 'What drops? Tell me. The girl is suffocating, her throat is already blocked up. For five days you allowed her to die ten miles away. Now what do you want me to do?' 'You know best, sir,' the old woman suddenly whined

from behind my left shoulder, her mock respectful tone making me loathe her instantly.

'Shut up!' I said to her. I turned to my assistant and instructed him to bring the little girl over. The mother gave the child to the midwife and she started to flail about, evidently wanting to cry but incapable of making a sound. The mother tried to fend us off, but we kept her away and I managed to look at the girl's throat with the laryngoscope. I had never seen diphtheria before, except for uncomplicated cases that I'd quickly forgotten. Her throat was full of ragged, white, pulsating membrane. The little girl suddenly got a breath out and spat in my face, but now I was so engrossed in thought that I didn't blink. 'Listen,' I said, surprised at my own composure. 'This is the problem: things are far gone and this little girl is going to die. Nothing will save her now — except an operation.' The word terrified me. Why had I said it? But I couldn't stop myself. Then the thought crossed my mind 'What if she says yes?' 'What kind of an operation?' 'I need to cut her throat near the bottom of the neck and put in a silver tube to allow her to breathe,' I explained, 'and then, maybe, we can save her life.'

The mother looked at me as though I had gone mad and put her arms around the little girl to shield her from me. The old woman started burbling again 'What? Don't you let him cut her throat! What? Her throat!' 'Get out, woman!' I said to her with malice. 'Give the child a camphor injection!' I told the medical assistant. The mother refused to hand the girl over when she saw the syringe, but we explained there was nothing to be frightened of. 'Maybe it will cure her?' the mother asked. 'No chance of that.' Then the mother burst out sobbing. 'Stop crying,' I said. I took out my watch and added 'I'll give you five minutes to make up your mind. If you don't agree in five minutes, I won't do it at all.'

'I refuse,' the mother said flatly. 'We both refuse,' the old woman added. 'As you like,' I added in a flat voice, and thought: 'Well that's that. It makes life easier for me. I've told them where we stand and offered to try. Look how lost for words the midwives are. They've said no, and I'm off the hook.' No sooner had I thought this, than a voice piped up that must have been my own 'Look, are you completely mad? How can you not agree? You'll kill the child. You have to consent! Have you no pity?' 'No!' the mother shrieked again. Inwardly I was wondering: 'What am I doing? I'm the one who's going to have to operate on the girl.' But I said 'Get a move on! Hurry up and consent! You must agree! Look, her nails are turning blue already!' 'No, no!' 'Take them into the ward. Let them sit there.'

They were led out into the gloom of the corridor. I could hear the women weeping and the little girl whistling. The medical assistant came straight back and said: 'They consent!' Everything inside me went cold, but I said in a loud clear voice: 'Quickly! Sterilise a scalpel, scissors, hooks and probe!'

A minute later I was running across the yard while the snowstorm whirled and raged. I rushed into my room. Counting the minutes, I grabbed a book, flicked to the page, and found an illustration of how to perform a tracheotomy. Everything looked straightforward: the throat had been laid open, the scalpel inserted into the windpipe. I started reading the text but couldn't take the words in — they seemed to be jumping around in front of me. I'd never seen anyone do a tracheotomy. 'Well, it's too late now,' I said to myself, glancing despairingly at the dark blue lamp and the smooth diagram. Feeling that I was about to undergo a terrible and fearsome ordeal, I rushed back to the hospital, oblivious of the storm.

In the surgery a dim figure in bulky skirts fastened itself to me, and a voice whined: 'Sir, how can you cut a little girl's throat? Surely you can't be thinking of that? She agreed to it because she's a stupid old woman. But you don't have my consent. You don't. I agree to giving her medicine, but I won't let you cut her throat.' 'Get this woman out of here,' I shouted, and added out of sheer spite: 'You're the stupid one! You! And she's the one with brains! Who asked you anyway! Get her out of here!' A midwife took the woman firmly and led her out of the ward. 'Ready!' announced the assistant abruptly.

We entered the small operating theatre and, as though through a glass darkly, I saw the gleaming instruments, the dazzling light, the oil cloth. For a last time I went out to the mother. The child had to be wrenched from her arms. All I could hear was a stifled voice saying: 'My husband's gone. He's in the city. When he comes and finds out what I've done, he'll kill me!' 'He'll kill her,' the old woman echoed, giving me a petrified look. 'Don't allow them into the operating room,' I instructed.

"I turned cold and sweat broke out on my forehead. I bitterly regretted studying medicine at all ..."

We were on our own in the operating theatre: my staff, me, and Lidka the little girl. Naked, she sat on the table and wept without a sound. Then she was laid on the operating table, strapped down, her throat cleaned and swabbed with iodine. I picked up the scalpel and wondered what on earth I was doing. In the theatre it was deathly still. I picked up the scalpel and made a vertical incision down her puffy white throat. Not a drop of blood emerged. Once again I brought the scalpel down the white line that had formed on the slit skin. Again, no blood. Slowly, trying to recall the diagrams in the textbooks, I tried to part the delicate tissue with a blunt dissector. Then from some point at the base of the wound, dark blood welled up, flooded the incision in a trice and ran down the neck. My assistant began to staunch it with swabs, but the flow didn't let up. Calling to mind everything but everything I had seen at university, I began to clamp the edges of the wound with small forceps, but this didn't help either.

I turned cold and sweat broke out on my forehead. I bitterly regretted studying medicine at all, and ending up in this godforsaken place. In recklessness brought on by desperation, I jabbed the forceps into the area of the incision, snapped it shut and the flow of blood ceased immediately. We swabbed the wound with pieces of gauze; and the incision lay there before me. Clean and absolutely incomprehensible. There was no sign of a windpipe anywhere. The incision I had made resembled

no illustration I had ever seen. I spent the next few minutes poking about in the wound blindly and inconsequentially, first with a scalpel, then with the probe, trying to locate the windpipe. After a couple of minutes I began to despair of ever finding it. 'This is the end,' I thought. 'Why did I volunteer to do this? I could have kept my mouth shut about the operation and Lidka would have died quietly on the ward. Now she's going to die with her throat cut open. And I will never be able to prove she would have died anyway, and that I didn't harm her.' One of the midwives silently wiped my forehead. 'Put down the scalpel and say you don't know what to do next,' I thought. Then I pictured the mother's eyes. I picked up the scalpel again and mechanically made a deep cut in Lidka's throat. The tissues parted and there before me, to my great surprise, was the windpipe.

'Hooks!' I cried hoarsely. My assistant handed them to me. I fixed a hook to each side and gave one to the assistant to hold. Now I concentrated on one thing only: the greyish rings of the windpipe. I thrust the sharp scalpel into it and froze — it was rising out of the wound. I thought my assistant had taken leave of his senses: he was tearing it out. Both midwives gasped behind me. I looked up and grasped what was happening: the assistant was about to faint for lack of oxygen and, with the hook still in his hand, was tugging at the windpipe. 'Everything's against me. I thought. 'Fate has it in for me. Now we've definitely killed her.' And as an afterthought: 'Once I get back to my room, I'll shoot myself…' Then the senior midwife, who was evidently very experienced, somehow darted over to the medical assistant, wrenched the hook from him and said through clenched teeth 'Carry on doctor…'

The medical assistant fell to the ground, his head thudding on the floor, but we didn't look round. I pushed the scalpel into the windpipe and then fed a small silver tube into the incision. It slid in easily, but Lidka remained motionless. The air wasn't entering her windpipe as it should have done. I took a deep sigh and stopped: there was nothing more I could do. I felt like begging someone's forgiveness, like repenting for my bright idea, repenting for having done medicine at all. Everyone was silent. I could see Lidka turning blue. I was ready to give up and burst into tears, when suddenly she gave a violent shudder and sprayed a fountain of disgusting lumpy matter through the tube: the air shrilled into her windpipe. As she breathed, the little girl began to sob. At that moment my assistant staggered to his feet. Pale and sweaty, he took one aghast look at the windpipe and helped me sew it up.

Through a blur of fatigue and sweat, I saw the midwives' happy faces, and one of them said to me 'Well, doctor, that was a brilliant operation'. I thought she was being sarcastic and glowered at her. Then the doors were thrown open and fresh air was let in. As Lidka was being carried out wrapped in a sheet her mother appeared in the doorway. She had the look of a wild beast about her. She was demanding to know what had happened. When I heard her voice, I felt a cold sweat run down my back when I realised what it would have been like if Lidka had indeed died on the table. But I answered her in a measured voice: 'Calm down, she's alive. And she'll survive, I hope. The only thing is we'll have to leave the tube in for the time being. She won't be able to talk, but don't be frightened.'

At this point the old woman materialised from nowhere, crossing herself before the door handle, me, the ceiling. But now she no longer made me angry. I turned away and ordered them to give Lidka a camphor injection, and to take turns on duty at her bedside. Then I went back across the yard to my room. I remember the dark blue lamp burning in my office, Doderlein lying there, and piles of books stacked everywhere. I walked over to the couch, lay down on it fully clothed, and flopped out immediately. I slept the sleep of the dead.

A month passed, then another. By then I'd already seen a stack of things and some more awful than Lidka's throat. I'd even forgotten about it. All around was snow, and my surgery got busier by the day. Then one day, already into the New Year, a woman came into the surgery holding by the hand a little girl, wrapped up as tight as a barrel. The woman's eyes shone. I took a better look at her and recognised her. 'Ah, Lidka! So how are you keeping?' 'Everything's fine.' We unwrapped Lidka's throat. She was scared and cowered from me, but I still managed to lift her chin and take a look. Her pink neck bore a brown vertical scar with two fine suture marks across it. 'Everything's fine' I said. 'You don't need to come back.' 'Thank you, doctor. Thank you' the mother said and ordered Lidka, 'Say thank you to the nice man!' But Lidka didn't want to say anything to me.

"Then I pictured the mother's eyes. I picked up the scalpel again and mechanically made a deep cut in Lidka's throat."

I never saw her again and I began to forget all about her. But the number of patients wanting to see me kept on growing. Then the day came when I saw one hundred and ten people. We started at nine in the morning and finished at eight in the evening. Reeling with tiredness, I was taking off my white coat when the senior midwife said to me: 'You've got the tracheotomy to thank for that waiting room. Do you know what they are saying in the villages? They say you gave a steel throat to Lidka when she was ill, and sewed it in instead of her own. They come to her village just to see her. That's fame, doctor. Congratulations.' 'So they think she's walking around with a steel throat now?' I asked. 'Yes, a steel one. And you, doctor, are a hero. You do everything so coolly. It's marvellous!' 'Yes, well, I never let things get to me' I said, not really knowing why I'd said so. Now I was too tired even to feel ashamed. I just looked away, said 'Goodnight', and went off to my room. Snow was falling in thick flakes, falling like a blanket over everything. The hospital light was burning and my house stood its own, imperturbable and imposing. And as I walked over to it I was yearning for one thing only. Sleep.

Mikhail Bulgakov, 1925
Translated by **Marjorie Farquharson**
and **Iain Bamforth**

Mikhail Bulgakov (1891–1940) qualified in medicine from the University of Kiev in 1916. Because of the war he was obliged, like many in his year, to practice in remote country hospitals and government clinics without the usual internship. This service, organised, funded, and run by local authorities (*zemstvos*), was one of the social institutions that functioned well in pre-revolutionary Russia, despite the dire roads and communications. Patients came from a different world entirely; however, Bulgakov takes them to task for their ignorance and superstition. He portrays himself as a beacon in the midst of deep surrounding darkness, an image nicely caught by the closing sight of his residence standing imposingly alone in the snow.

Bulgakov worked for 18 months near Smolensk, in the north-west of European Russia; he fought for the Whites in the civil war and in 1921 abandoned medicine to concentrate on his theatre and prose writing. He was a consummate risk-taker, and had endless troubles with the Soviet censors. Just before his death he completed a Faust novel called *The Master and Margarita*, his masterpiece. *Notes of a Country Doctor*[1] was put together only after his death from a handful of stories and articles published in long defunct medical journals, such as *Meditsinsky Rabotnik*.

Bulgakov's story is one that anyone who has worked in an isolated bush hospital can identify with. A novice is on his first clinical assignment, miles from help, and all too conscious of his inexperience. The child brought to casualty by the mother and grandmother is moribund, her diphtheria too advanced for remedy. The women have waited five days before attending: the only thing which might help is an external airway. So he terrifies himself — and them — by proposing to do a tracheotomy. Consent, it may be noted, is obtained in conditions rather different from those laid out in today's rulebook of Good Medical Practice.

As Jack Coulehan has written,[2] the usual framework for clinical objectivity urged on doctors gets skewed in this story. Dispassionate reason would tell the young doctor (a) that he is hopelessly inexperienced, (b) that the girl is unlikely to survive at this point, and (c) that it might be kinder to all concerned not to butcher her in the light of (a) and (b). It is, in fact, emotion which prompts him into action. Despite being assailed by terror, regret, and anger, during the operation he remains 'astonished at his own calm'.

This overturning of one of the tenets of good medical practice — emotional distance — and the ethical issues raised by Bulgakov's story can be compared with the more ambiguous situation in William Carlos Williams' story, *The Use of Force* (1933), also about a young child with diphtheria.[3]

Iain Bamforth

References

1. Bulgakov's country doctor stories have been translated, excellently and in one volume, by Michael Glenny (London: Collins Harvill, 1990).
2. Coulehan J. Tenderness and steadiness: emotions in medical practice. *Literature and Medicine* 1995, **14(1):** 222-236.
3. Carlos Williams, W. *The Doctor Stories*. New York: New Directions, 1984: 56-60.

It is, surely, every doctor's nightmare. A patient presents with an acute, life-threatening problem requiring an immediate intervention in which the doctor has little training and no experience. No one else is available. The doctor must act or the patient dies.

Reading this brilliant translation of Bulgakov's *The Steel Windpipe* evoked in me memories of about 30 years ago. I was handed a 'flat' baby with no spontaneous respiration following delivery, owing to the administration of pain relief to the mother too late in the confinement. The tiny baby was blue and apparently lifeless; without intubations she would die or survive with gross brain damage. There was no other doctor present.

My overriding emotions were of terror, awesome responsibility, awareness of the implications of failure, and of inadequacy. 'I bitterly regretted having studied medicine.' The outcome in my case was similar to Bulgakov's and for the same reasons. Gazing with increasing panic into the baby's mouth, an orifice suddenly appeared. I slipped in the endotracheal tube. By chance, and nothing else, the tube was correctly positioned in the trachea rather than the oesophagus, and after a short period of ventilation the baby breathed spontaneously, and survived unscathed. Serendipity rules again.

There is a striking authenticity in this short story, which is clearly autobiographical. Many other doctor–writers display similar authenticity. Anton Chekhov's short story, *The Enemies*, published in 1887, contains a remarkable description of a room in which a young boy has just died, recognising the unique quality of the stillness and silence in these surroundings:

> *'Here, in the bedroom, the quietness was of death … the very air heavy and stifling, all was motionless and seemed engulfed in stillness.'*

William Carlos Williams, in his collection *The Doctor Stories*, has an unsettling tale, *The Use of Force* with similar basic facts to the Bulgalkov. The doctor visits a young girl with a sore throat who may or may not have diphtheria. She refuses to have her throat examined and resists with all her physical strength. Williams recognises that this becomes a contest of wills between the youngster and the doctor, and the 'Use of Force' eventually breaks her spirit, but also reveals that she does indeed have diphtheria:

> *'And there it was — both tonsils covered with membrane. She had fought valiantly to keep me from knowing her secret. Now truly she was furious. She had been on the defensive before, but now she attacked. Tried to get off her fathers' lap and fly at me while tears of defeat blinded her eyes.'*

General practitioners have access to an inexhaustible supply of narratives of patients' lives, and indeed we are often in the privileged position of being an integral part of that narrative. Perhaps more of us should write of our experiences, both for the reassurance of our colleagues that we all experience a maelstrom of emotions in clinical encounters, and to inform our patients that uncertainty and fear of failure are not infrequently part of the medical transaction.

Benny Sweeney

The Troubled Helix:
social and psychological implications of the new human genetics
Edited by Theresa Marteau and Martin Richards
Cambridge University Press, March 1999
PB, 360pp, £18.95, 0 52158612 7

As a society, we are scientifically illiterate, particularly when the science is medical. Broadsheet readers are expected to understand the technicalities of Keegan's flatback four and their relationship to his downfall. They are also expected to understand the full implications of a fall in the Euro's value of 0.1 cents and to care. Yet these things affect many of us only marginally. The same readers, however, were told no more about Donald Dewar's drug treatment than that it is 'the same as rat poison', and that it 'thins the blood'. They are also entitled to expect the influenza vaccine to confer immunity to winter colds, because every upper respiratory tract virus is referred to as 'flu'. Such woolly euphemisms, I believe, arise from and contribute to a willful desire to hide from knowledge that is feared, which is knowledge of the malfunctioning human body, or a distorted version of the self.

It's different, of course, for us in the medical profession, for we are well informed and do not know this fear. Or do we? One of our responsibilities, particularly in general practice, is to allay this fear by communication and explanations that lead to an understanding of medical science and technologies. Genetics is one area where our understanding or fluency may be such that we cannot reassure, and instead we increase anxiety. This may further prevent proper public understanding.

This book was compiled to facilitate public debate around the many issues that arise from the recent dramatic advances in the science of medical genetics: 'Informed public debate needs an informed public, and that includes health professionals', says one of the authors. The book, reassuringly therefore, assumes little prior knowledge, and approaches the issues from a clear starting point. The issues are, as the title suggests, social and psychological, and they are also ethical. The book covers a wide range of these, in a logically laid out series of highly readable chapters, written by specialists, who cite the scientific literature extensively. With a couple of exceptions, there is only limited overlap between the chapters, and the debate is generally balanced.

One of the themes is that genetic science has advanced with little reference to the social and psychological implications, yet many of the studies cited by the authors are 30 or 40 years old. Perhaps one of the successes of the book, therefore, is to combine all the evidence into a single presentation, and to raise its profile and impact accordingly. Another parallel success is to highlight both the need and the important areas for further research (such as the impact of giving birth to a genetically ill child that could have been detected prenatally).

Another theme relates to the rise in the profile of genetic diseases, and the section devoted to personal histories focuses on these. A quick view of the epidemiology of these conditions shows that they are still of minor importance compared with conditions that are not (at least yet) considered genetic. Yet, the importance lies more in the potential, to detect, to prevent (i.e. abort), or even create genetic particularities, and recent media attention has reminded us of the importance of considering the implications at the earliest possible stage. This must be done scientifically at the same time as the laboratory science.

Two criticisms of the book. The first section, which aims to lead us in to the science by presenting personal case histories, is frankly boring and added little. But perhaps that is because the views presented were all familiar to me in daily practice, and my wife liked the section. Secondly, many of the issues could be (and are) wider than genetics: antenatal diagnosis (a major theme) and population screening, for example, are much wider than the narrow focus implied by this book and deserve wider consideration.

In the end, however, I was enlightened by this book, and welcomed its contribution to my library.

Blair Smith

The Blood of Strangers
Frank Hulyer
University of California Press,
September 1999
HB, 160pp, £13.99, 0 52021863 9

Second Opinions: Stories of intuition and choice in the changing world of medicine
Jerome Groopman
Viking Penguin Inc, March 2000
HB, 243pp, £17.50, 0 67088801 X

'*And what is the use of a book*', *thought Alice,* '*without pictures or conversation?*'

Lewis Carrol, *Alice in Wonderland*

These two books are all illustration and conversation: word-pictures of patients and doctors, relatives and nurses, and the deeper understandings gained from their discussions. Person-to-person relationships are at the heart of medicine and nursing, says Jerome Groopman. 'How essential it is for patients to voice their feelings, intuitions, and need to their doctors. This isn't a matter of self-expression. It's about the information a physician or nurse must have to make the best possible diagnosis and arrive at the best possible treatment. Quality medicine depends on doctors talking to patients about their full treatment options, as well as listening to what patients want, need, and

sense is happening to them.'
Jerome Groopman and Frank Huyler offer a window onto intimate medical situations, and the ensuing personal views and feelings, dilemmas, confusions, frustrations, anger, and compassion __ valuable material for students, trainees, and practicing doctors. It's also remarkable and useful reading for non-clinicians. We are all patients at times.

Second Opinion is avowedly more than a story book. Groopman, a medical professor and leading researcher in cancer and AIDS, aims to support both patient and physician readers to be more confident with the use of 'second medical opinion', and to voice their own opinions and feelings audibly. He also encourages physicians to join their 'intuition with that of the patient', since critical treatment decisions are too often made in partial ignorance.

The Blood of Strangers is a remarkably unclichéd collection of brief but gripping snapshots of ER encounters __ beautifully and tersely written by Frank Huyler __ offering much insight into ethical dilemmas. A good read (aeroplane and beach for me), giving insight behind normally closed doors or curtains into relationships between clinicians, patients, and relatives, and among clinicians, such as the brilliant young woman neurosurgeon who was found to be snorting two lines of coke before work, and practising magic. But the book confirms what I suspected __ that the longitudinal relationship between doctor and patient in general practice, generally lacking in ER medicine, gives an unparalleled depth of understanding, compassion and care.

Second Opinions has longer stories, three of which concern Jerome's own family — the best in the book. These offer insight into the way he allowed personal as well as professional experiences to deepen his awareness and skill as a diagnostician and supporter of others. One about his baby son nearly dying from an intestinal blockage is beautifully and caringly told. Some of the others, though, are rather long-winded, detailed and repetitious. An amusing masculine (all the consultants are male) competitiveness in diagnosis, knowledge of the field, and care is also displayed. And Jerome depicts himself as rather a heroic gentle giant (we are repeatedly given his height and professional academic status). But his compassion and 'passionate care of patients' is very real. Another excellent beach and plane read.

One of the sad things always about American texts is the waste of energy and time on money issues The lack of care to which this leads is often addressed __ a whole arena of issues which, despite the gaping wounds in the Health Service, we are spared.

Read both. Then find some nice paper and a comfortable pen, and write your own.

Gillie Bolton

24-Hour Primary Care
Edited by Chris Salisbury, Jeremy Dale and Lesley Hallam
Radcliffe, July 1999
PB, 248pp, £19.95, 1 85775311 9

If you want to know about modern out-of-hours cover arrangements, and you probably will because few subjects are more interesting to GPs, this is the place to look. With one exception, which I will come to, it covers all aspects of the subject. It is clearly set out, in three main sections, the first setting the scene with the basic issues, including an admirable survey of arrangements in other countries, the second getting to the details of deputising services, GP co-operatives, GPs in A&E departments, nurse telephone consultations, nurse-led minor injury units and patients with particular needs, and lastly the three editors, Lesley Hallam, Jeremy Dale, and Chris Salisbury respectively discuss integration of services, quality assurance, and a vision of the future (perhaps with NHS Direct becoming the universal portal).

For a book with 12 authors an exceptional cohesion of style has been achieved, and the expertise of the different contributors is expressed in voices which appear equally articulate and intelligent. Boxes, tables, and quotations are appropriate and helpful and the presentation is up to the high standard we expect of Radcliffe.

The kind of 24-hour primary care that is not covered happens to be the kind I take part in myself; the 'old-fashioned' one-in-four rota that we have reverted to since nine of our old one-in-13 rota colleagues joined a rural co-operative. I am writing this on the Sunday afternoon/evening of a weekend on call, during which (excluding Saturday morning surgery) I have had seven contacts in all since Friday, none of them at night, which is typical. With a professional answering service, a message master pager, and a pocket phone we too have benefited from the technological change rightly celebrated in this book. The last time we did a one-in-four rota we had none of these, not even a phone we could carry around the house. My wife couldn't have a bath if I was out. Today our personal service, terminal care cover, and cover of the GP ward seem very good and the patients have responded with gratitude and an uncanny reduction in their call rate.

Ours is not an answer for city practice, of course, nor for doctors who cannot relax on call however quiet they are, nor for those who feel (and are) vulnerable without an escorting driver. But the impression remains that patients are nothing like as enthusiastic about out of hours co-ops as their doctors. Except, that is, for a BT sales lady who rang me last year from Liverpool and (when she realised I wasn't interested in what she was selling) got onto the subject of how wonderful her new out of hours call-in centre was.

She certainly made me think. And so do the measured, thoughtful, honest writers of this book. It is a substantial contribution to the discussion of an extremely important subject, central to patients' perceptions of their doctors, and it is to be wholeheartedly welcomed and widely read.

James Willis

The National Gallery, London

Do drop in at the National Gallery in London, and pick up on two concurrent exhibitions: *Telling Time*, which is free, and *Impression* which is good value at £7.

Telling Time is a conceptual study of how time is depicted in painting: the passage of time, speed of motion, past and present. Examples include Leopold Egg's triptych of 1858, of a destitute wife confronting her past and her present situation in a simultaneous 'freeze frame'. Fascinating as these time capsules are, the extra attraction is the room with a high-tech tracking device, installed by Derby University, which charts your eye movements as you study a painting (although this can be embarrassing when the general public witnesses your eyes being drawn to certain parts of the model's anatomy!).

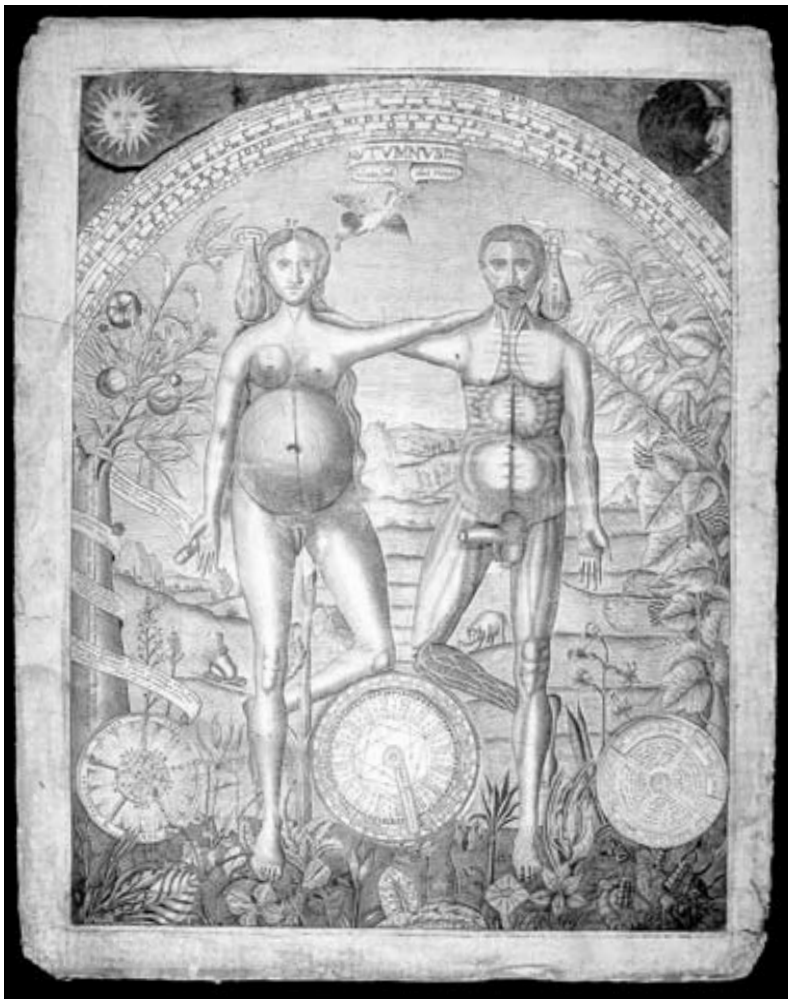
For contrast, take in *Impression* as well. You may feel that the impressionists have been done to death, but this show takes a different angle: the subtitle of the exhibition is 'Painting Quickly', and it focuses on the impetus for rapid, improvisatory painting that Manet initiated in the 1860s. We might have thought of impressionism as characterised by depiction of light, or the artist sketching *en plein air*. But this show demonstrates the extra angle of the rapidity of the impression: 'almost without conscious thought, but with an intelligence of hand'. There are great treasures here that you might not have seen before: a Sisley study with dashes of autumn orange and blue beside the Seine, or Renoir's *Road at Wargemont*, where the paint strokes seem suspended, washed lightly over the canvas. The catalogue, at £9.95, will solve all your Christmas presents with one swipe of the credit card!

Brenda Stones

Spectacular Bodies

Hayward Gallery until 14 January 2001

The first images you encounter in this show, which looks at the relationship between medicine and art, are of Dutch surgeons of the 16th and 17th centuries dissecting cadavers before an audience, grouped just as you might be presented with the trustees of an orphanage or the members of a militia company; the surgeon's is a noble and honourable calling. However, anatomy's main purpose was not to permit the development of treatments but to establish what a human being is. In this it shared an aim with art, and the resurrection men of course, supplied both anatomists and painters. This blend is illustrated by one of the many écorché figures cast from life, of the flayed corpse of an executed smuggler posed as the famous 'Dying Gladiator', the one butchered to make a Roman holiday in Byron's poem. Medical humour has always seemed callous to the layman, so I shouldn't really find this distasteful, I suppose. This sits among a number of wax models of dissections which can be hard for the squeamish (like me) to look at, but their value and even their beauty are clear, notably Pinson's 'Anatomy of the Hand'. I cannot say the same about John Isaacs' 'A Necessary Change of Heart', one of a number of modern works included, which looks like a half-eaten human corpse on a slab, and which does not illuminate the models with which it is shown at all. Thankfully, the best room follows, of staggeringly beautiful drawings by the greatest European artists, including Leonardo and — a real discovery — the Dutch medical illustrator Jan Wandelaar. The very title of the largest work, 'Muscle-man seen from the front with rhinoceros', should be enough to make you want to see it.



The Four Seasons, mid 17th century
c. Duke University
Photo c. Bill Bamberger

Just as the first part of the show focuses on the examination of the body, so the second is devoted to past efforts to understand the mind. This includes such 19th century fads as phrenology, and the rather more dangerous eugenic theories of Francis Galton. Both now look equally ridiculous. What is startling is the extent to which men of the calibre of Gericault could believe that there is a facial type characteristic of, for instance, a child kidnapper. It is a short step from here to caricature, and the Daumiers used to illustrate this are wonderful. The exhibition ends with a remarkable installation by the American artist, Beth B, which was inspired by the treatment of 'hysteria'. This includes such bizarre gadgets as the 'ovarian compressor', and offers some alarming quotations from male doctors of the past on the nature of female sexuality. This is the most telling juxtaposition of old and new in the show, since beside it hangs a heroic painting, clearly in the same tradition as the Dutch pictures in the first room, of the inventor of the compressor lecturing on hysteria in Paris in the late 19th century.

This is an engrossing exhibition, especially for GPs, who seem to me to stand at this exact cusp of science and art.

Frank Minns

In 1683, in Amsterdam, Jan van Neck painted the 'Anatomy Lesson of Dr Frederick Ruysch', a large canvas showing the public abdominal dissection of a stillborn infant. Looking at it, perhaps sensitised by the current outcry over the retention of body parts without parental consent by a number of children's hospitals, I found myself hoping that the infant's mother had died at the same time as her child. If not, how could she have endured the destruction of the body of her precious child as public theatre?

The picture is shown as part of the 'Spectacular Bodies' exhibition in London, which charts the evolution of the medical gaze from the brilliant anatomical drawings of Leonardo da Vinci. We see, with sometimes startling clarity, how quickly the new-found gaze turns the body into an object that can be dissected without horror, fear, or pity. Almost immediately we lose sight of the unique human subject. This process leads inexorably to the final section of the exhibition where 19th century

photographs of various 'types' of 'defective' person illustrate the crudest form of the sort of generalisation which can only be made by someone who has lost sight of the unique individual in front of them.

At what point does art cease and become merely a technical image — a drawing or a model? Perhaps at precisely the point when it sacrifices all sense of the dignity and sensibility of the human subject being scrutinised. Without that sense, the gaze is cruel — almost abusive. Yet the exhibition's curators seem almost completely unaware of the fraught ethical implications of their achievement. There is only one mention of the people whose bodies were dissected and this comes early on when we are told: 'the corpses were almost always those of executed criminals, whose sentence could include the posthumous degradation of dissection'. The degradation is never even hinted at again, apparently dismissed in the interests of science and the pursuit of the body as spectacle. In the end, the exhibition seems less concerned with the borderline between art and science, and is revealed as a disturbing, but salutary, exploration of the borderline between acceptable and unacceptable ways of treating other human beings.

Iona Heath

A Christmas Gift from Siberia

for Tony and Patrick

Santa lays his hand
on my head, and yours —
a shaman
with gifts of healing
from worlds
the other side of the mushroom*.

Rudolph carried him,
his nose as red as the scarlet fungus
with white spots*
he shared with his master
to fly to the lands of wisdom.

Come into my house
where we huddle for warmth
underground;
there's no need to knock
at my open door in the roof
where the smoke drifts out
from the fire.

Welcome Santa
brave traveller,
healer.

Gillie Bolton

*Fly agaric, the shaman's hallucinogenic fungus

Trefor Roscoe

Bimbling in cyberspace

The great thing about the internet is the randomness of the links and its ability to open up completely new views on life. I knew that it was possible to play chess by e-mail, but had not appreciated the size of the internet chess community and the sophistication of the software until I tried to find somewhere to play against my son. He has just got interested and as I work away a lot I did some surfing to find a place to play. There are thousands of sites with innumerable games in play. You can watch, comment, join in, challenge someone, or even play a group match with moves being made by the consensus of the hundreds of players on each side. One of the largest and most comprehensive with over 2000 games in progress when I looked is **www.chessclub.com**. With free games of speed chess it costs $50 to register. The Free Internet Chess Server (**www.freechess.org**) is nearly as good, and is obviously free.

For one-to-one play, a good starting point is **www.itsyourturn.com** where you can play chequers and other games including Battleship on a one-to-one basis. Come and challenge me to a game — my username is TreforR. You receive a graphical representation of the board and can move with mouse clicks and drags. The free servers have time-limited games with up to 10 minutes to play. I usually lose in less time than this!

The history of the game is well covered on the internet. I learnt that there are still distinct variations that still have their own fans. **www.chessvariants.com/** has a useful history and pointers to where the variations can be found. They also have the ability to download a programme that allows you to play the variants with all their odd rules! The original game from over seven centuries ago, called *Chaturanga*, features elephants instead of bishops and a counsellor instead of a queen. The ancient Chinese version, Xiang Qi, deals with elephants, horses, cannons, and generals. Chariots and cannons move like rooks, horses travel like knights, and counsellors can only move one diagonal space at a time. All the common variants can be played at sites listed at Palamede (**www.palamede.com**)

James Mackenzie Prize

Notice is hereby given that the trustees of the James Mackenzie Trust have discussed and agreed a model resolution for the expenditure of capital from the above fund.

The James Mackenzie Prize was established in 1956. The award is made every five years and will be awarded next year. The prize is awarded to a general practitioner in the Commonwealth who has undertaken or published valuable work during the previous five years, the intention being to reward good clinical, and good research work, done in general practice.

The costs of administering the trust fund for some time have been disproportionate to the value of the fund of the income produced by it. The Charity Commission has advised the College that it is possible to transfer the capital funds of the prize to the College as an educational body to administer. The trustees have unanimously voted in favour of this.

Chairmanship of Membership by Assessment of Performance Implementation Group

Dr Iona Heath has chaired the Membership by Assessment of Performance Implementation Group since its inception but, now that the first assessment has been completed, she has indicated that she would like to stand down as soon as a suitable successor has been identified.

MAP is the new route to College membership (available since April 1999) which uses three methods of performance assessment: the MRCGP video examination (or simulated surgery), written material based on criteria set out in the MAP handbook, and a practice visit to the candidate's surgery.

The Implementation Group meets four times a year at Princes Gate and currently has 13 members, including representatives of the faculties, the Examination Board and the Assessment Network, and the Chairman and Honorary Secretary of the College. The Patients' Liaison Group has also been asked to nominate a representative. The full-time MAP Administrator services the meetings, and the Head of Networks and Membership also attends.

The agenda generally includes the following:

- *The MAP regulations*. These are outlined in the MAP handbook, but have had to be refined as candidates make progress (the first MAP practice visits are due to take place shortly).
- *The MAP criteria*. Again, these are subject to the process of annual review, and are formally approved by Council in January, ready to be issued in April.
- Training and appointment of MAP assessors.
- Training and support for MAP candidates.
- MAP applications and the overall results of candidates in the video/simulated surgery examinations.
- Important items of correspondence from assessors, candidates, etc.

Between meetings the Chair needs to be available to advise the MAP administrator and Head of Networks and Membership by e-mail, telephone etc, and on occasions to advise candidates, assessors, and advisers directly. He or she will receive requests from faculties and occasionally outside bodies to speak about MAP, and will also be expected to represent MAP at meetings of the Assessment Network, which also meets four times a year.

The successful candidate will be an RCGP member of at least five years' good standing. A detailed knowledge of MAP is not essential, though it would be an advantage. The new chair will need to have the following:

- The ability to quickly gain an understanding of the MAP regulations and criteria.
- A sympathy with the objectives of MAP.
- The ability to control meetings effectively.
- The ability to work with College staff and members.
- An awareness of the context of MAP — the College's commitment to a range of quality and assessment programmes, revalidation, etc.

For an informal discussion of the Chair's responsibilities, please contact Dr Iona Heath at **pe31@dial.pipex.com**. If you wish to confirm your interest, please contact Mike Powell, MAP administrator on extension 266 at Princes Gate, or at **mpowell@rcgp.org.uk**.

agm

Minutes of the Annual General Meeting of the Royal College of General Practitioners held on 17 November 2000 at 2.00pm at the Paragon Conference and Exhibition Centre, 47 Lillie Road, London SW6.

The President, Professor Sir Denis Pereira Gray was chaired the meeting.

More than 25 members were present in person and therefore a quorum was present. Notice of the meeting had been circulated with the October issue of the *British Journal of General Practice* published on 2 October 2000.

After welcoming everyone to the meeting, the President introduced the **Special Business** on the agenda:

Appointment of Honorary Fellows
Professor Graeme Catto, Baroness Emerton of Tunbridge Wells and Clerkenwell, Professor Per Fugelli and Professor Barbara Starfield were appointed Honorary Fellows of the College. Professor Catto, Professor Fugelli, and Professor Starfield were presented with their Fellowships, Baroness Emerton being unable to attend.

Presentation of Awards and Scholarships
The President presented Awards and Scholarships as set out in the booklet *Awards and Fellowships 2000*, tabled at the meeting.

Appointment to and Presentation of Fellowships
The Meeting appointed to Fellowship those members whose names appeared in the booklet *Awards and Fellowships 2000* tabled at the meeting. The President formally presented the Fellowships.

James Mackenzie Lecture

Professor Professor Per Fugelli, of the Institute of General Practice and Community Medicine, University of Oslo, presented the James Mackenzie Lecture 2000 with the title 'Trust In General Practice'. The lecture was warmly received by everyone at the meeting.

Routine Business

Annual Report of Council 1999–2000

The Chairman of Council, Professor Mike Pringle, presented the Annual Report of Council for the year 1999–2000 and highlighted the major events and issues. The report was adopted *nem con*.

Accounts for the Year 1999-2000 and Auditors' Report

The Honorary Treasurer, Dr Tony Mathie, presented the Accounts for the year ended 31 March 2000 and mentioned some specific matters. He also presented the report from the College's Auditors. The Accounts and the Auditors' Report were adopted *nem con*.

Auditors

Messrs Buzzacott were duly proposed and appointed as Auditors until the 2001 Annual General Meeting. The meeting authorised the Council to agree arrangements for fixing the remuneration of the Auditors.

Appointment of the President for 2000–2003

Following her success in the contested election earlier in the year, Professor Dame Lesley Southgate was formally proposed as President of the College 2000–2003. This was approved *nem con*. The outgoing President spoke warmly of his successor who responded in appropriate terms. The portrait of the outgoing President was presented.

Council

Following their success in the elections earlier in the year, the following were formally appointed as the six elected members of Council to serve from 2000–2003: Professor Yvonne Carter, Professor Ruth Chambers, Dr Jim Cox, Dr Keith Donaldson, Dr Philip Evans and Dr Shaun O'Connell.

The Honorary Secretary of Council, Dr Maureen Baker, announced the Faculty representatives appointed to serve on Council 2000–2001 and the other members who would serve on Council in 2000–2001.

Spring Symposium 2001

On behalf of the Northern Ireland Faculty, Professor Scott Brown spoke about arrangements for the Spring Symposium 2001 and encouraged all members to attend.

Date and Time of next Annual General Meeting

The Honorary Secretary announced that the next Annual General Meeting would be held on Friday, 16 November 2001 at 2.00pm at a venue to be announced.

Maureen Baker
Honorary Secretary of Council

neville goodman

Let me tell you a story.

Once upon a time, a Top Doctor had an idea about how to solve all the ills of the NHS. He called it Clinical Governance. He wrote glowingly about how it would, among other things, mean that everyone in the NHS would always get on with one another and agree on how to do things because they would always be led by understanding bosses. Medical treatments would always work because from now on they would be guided by evidence-based medicine. New treatments would develop apace because there would be easy ways of spreading information throughout the service. Bad doctors wouldn't stand a chance because everyone would know what was being done and no patient could ever die needlessly or receive the wrong diagnosis.

There were some other doctors — spiteful, churlish creatures — who weren't so convinced. They seemed to think it was yet more unproven reorganisation. They asked what was in clinical governance except fine words. They knew that the NHS was sorely stretched, and yet there were no extra pennies for clinical governance, let alone for relief of the stretch. The Top Doctor carried on, carrying his message around the country. The spiteful churls wondered if he was ignoring their worries, or had just dismissed them as of no account.

Then a pow-wow was convened. All manner of docs and para-docs were there — friends of the Top Doc and spiteful churls. They each stood up and gave voice, for the audience to judge: will clinical governance save us? To take the message beyond the listeners, the convenor collected the written wisdom of the speakers to bind it in a book. But, lo: only the words of the spiteful churls appeared!

So let's break away from the fairy tale. The conference was held at the Royal College of Physicians in March 2000. Seven months later, all the chapters from speakers critical of clinical governance are ready. The others, it seems, are unhappy about writing chapters to appear in a book that is not 'on-message'. As someone unconvinced by clinical governance, I could not look for better evidence of its hollowness than the inability of its enthusiasts to write convincing arguments of its worth, especially as they have now had a full opportunity to hear the worries of its critics. What is more, their procrastination is delaying the publication of the book while the clinical governance juggernaut — free from the burden of intellectual discussion — hurtles on.

Nev.W.Goodman@bris.ac.uk

Iain Bamforth 'was a kind of Kaspar Hauser at medical school: straight in to science from the *End of Days*'. Discuss. He writes books and literary criticism for a variety of periodicals, in a variety of languages. His reflections on Chekhov's journey to Sakhalin will be published in the *Journal* during 2001

Gillie Bolton, poet and humanist, is also a research fellow in medical humanities within the Institute of General Practice Community Sciences Centre, at Sheffield University

Marjorie Farquharson works for the Council of Europe's Human Rights Division in Strasbourg, and travels frequently to the Russian Federation

Jim Ford was a GP in Lancashire for 12 years before becoming a medical civil servant. He is Medical Director of the Job Retention Pilots at the Department for Education and Employment

Only at Christmas time could we point out that **Neville Goodman** puts people to sleep both professionally, as an anaesthetist, and in his spare time, as a freelance medical editor

Phil Hanlon is Professor of Public Health in Glasgow

Richard Hayward is a GP in Newcastle under Lyme, Staffordshire

Iona Heath is a GP in Camden, London. She chairs the RCGP's Ethics Committee. She led the communal singing after Per Fugelli's recent, and majestic, James MacKenzie Lecture (coming soon...)

Paul Hodgkin, yet another Sheffielder, knows about sailing and midges and childhood on the west coast of Scotland

Frank Minns wanders Clapham Common with two labradors named Daphnis and Chloe. He remains a senior naval officer

Wendy Muircroft knows New Zealand, Nepal and Alan Munro intimately

Trefor Roscoe is a high-techie Sheffield GP who can respond to editorial deadlines with no hesitation whatsoever

Blair Smith is a senior lecturer in the department of general practice, Aberdeen. Like many academic GPs he yearns for the solitude of wide oceans, and may soon be part of the Royal Naval Reserve

Brenda Stones is an art historian, currently at the National Gallery in London

Benny Sweeney is a GP in Govan, Glasgow.

James Willis' new book, *Friends in Low Places* will shortly be available, from Radcliffe

Tim Wilson is a fierce EBM-ite from Oxford, but he carries the burden gracefully

All of our contributors can be contacted via the Journal office

james willis

The wrong kind of risk

With the entire world except for me going off on 'risk-assessment' courses, not to mention the entire world except me knowing what 'risk-assessment' means (because it can't just mean 'assessing risk', surely?) you would think that the whole world except me would be good at assessing risk. But it isn't.

What is everybody else learning? I want to be told.

A train comes off the tracks and four people are killed. Which, of course, is a great tragedy. But there are other great tragedies which do not bring the transport systems of nations to a halt.

I decide to surf the net to make some comparisons and find myself deep inside the Department of the Environment's website. A good year to compare is 1998 because that is the last year for which road accident death figures are available (they take a long time to count) and by a happy chance there are some rail accident deaths for that year as well, several of the neighbouring years having none.

So here we are: rail-accident deaths for 1998: seven (far more suicides of course, but that''s another matter) and — surf again for a while — road accident deaths for 1998: 3421.

Now, if I were running a course on something called risk assessment and had asked the class to say which of two means of transport they would summarily close down, given that one caused 488.7 times as many deaths as the other, I know which I would want them to suggest. And if they came up with the other I would not so much fail them as recommend them for psychiatric treatment, if not incarceration. The fact that our lords and masters, trained, no doubt, in risk assessment until their ears fizz with the relevant jargon, fell headlong into this elementary howler does nothing to reinforce the dutiful respect in which we long to hold them.

Unless, of course, we are talking about the wrong kind of risk. And that of course is the explanation. They are not talking about the risk to travellers. They are talking about the risk to themselves. That's the sort of thing that risk assessment courses are designed to help you avoid. The whole point about rail accidents is that somebody can be blamed. Everybody knows that lots of people get killed on the roads, but every rail accident, or near miss, is somebody's fault.

So that is why exceptional steps must be taken. That is why docile citizens must stand platform-packed for hours, transfixed by an infinitesimal threat. That is why the repair of an entire rail network must be suddenly fitted into the wettest weekend in history, begging all sorts of questions about where the expert manpower and the specialised equipment could be found to do all at once what is normally a programme of rolling maintenance.

But like any other ruling that comes under the heading of health and safety, discretion is out of court. The recommended precaution is mandatory, entirely irrespective of financial and human cost. The whole thing is utterly daft. No way to run a railway.

We live in a society which is hopelessly muddled about risk, and the more we talk about it, the dafter we seem to get. I am not proud to parade my ignorance, but society seems to be reaping a bitter harvest after its high summer of 'risk assessment'. It seems to me that we need good old-fashioned common sense, and lots of it.

And for heaven's sake let us leave that meaning exactly what it has always meant. The last thing the country needs is for us all to stop work yet again to go off on common sense courses. But I wouldn't be the least surprised if that becomes the next Big Idea and none of us are allowed to use common sense unless we've got the certificate.

And now I've got that off my chest, anyone for a spin in the car?