

The Back Pages

viewpoint

Can GPs still identify children at risk? What is our role?

THE publication of *Out of sight*¹ forced me to ask why I now see far less diagnosis and management of child abuse. The answer lies in the changes that have occurred, and continue to occur, to GPs and their working practices. In the past, diagnoses were made on home visits where a parental attitude to an illness or injury seemed inappropriate. This often occurred out of hours or in a stressful situation. The incessant pressure on time has forced GPs to change their working practices. GPs do not see children in their own homes any more. Routine daytime visits to children are discouraged and children are brought to the surgery. The introduction of triage has increased this trend. When consulting out of hours, children are expected to attend a centre. The concentration on filtering access to a doctor based on medical need reduces the chance of observations that add up to a diagnosis of abuse. While it is still possible to diagnose abuse it is a great deal easier for an adult to cover it up. The latest move toward telephone or e-mail consultation will allow diagnostic signs to be deliberately hidden.

GPs are still respected in the community, and neighbours or relatives do bring suspicions to GPs; however, the response is to refer and GPs are rarely involved in the case conference or follow-up arrangements.² Patients soon learn that GPs will not be able to effect change and go to the other services directly. Most GPs have stopped believing they have a role in the management child abuse.²

Despite all the investment in other professionals, none is equipped to see large numbers of children and diagnose medical problems. None can bring together care of the whole family and their illnesses in quite the same way as GPs did in the past. Health visitors can provide some similar skills but they cannot replace the medical input and diagnostic skills of a GP. Health visitors do see all children but concentrate on a subgroup of families known to be under stress. They do not see the families that appear calm where abuse can and does occur. The fragmented nature of the developing service makes it easy to take a child to another service when ill.

Unless something changes, GPs will continue to have a diminishing role in the diagnosis and management of child abuse. New systems involving many more professionals and specialists have replaced the GP. The GP's job role has moved on and GPs have accepted the change in this area as in so many other traditional family doctor roles. The replacement however is not really any better; cases are missed and mistakes still occur even after abuse is recognised.

If the incessant pressure on time could be reversed then GPs could again have a role in child protection. The inefficient ways of working, such as home visits and making emergency appointment available without a filter, would allow continuity to return to the service. There would be a cost to allow a reduced list size; however, the savings elsewhere are much larger than the GP cost. At present, even GPs themselves probably don't believe in the possibilities of their own service to improve patient care. We know that increasing the number of GPs in an area reduces the death rate³ and this is an example of the mechanism. GPs need to throw off the attitudes enforced on our profession, believe in themselves and their ability to help families, and shout long and loud that the replacement of GPs is a false economy. Unless we do, child abuse will remain out of sight.

Andrew Spooner

References

1. *Out of Sight: An NSPCC report on child deaths from abuse 1973-2000* is available at a cost of £12.50 (inc. p&p) from the NSPCC Publications Unit. Tel: 0207 825 2775.
2. Lupton C, North N, Khan P. What role for the general practitioner in child protection? *Br J Gen Pract* 2000; **50**: 977-981.
3. Jarman B, Gault S, Alves B, *et al*. Explaining differences in English hospital death rates using routinely collected data. *BMJ* 1999; **318**: 1515-1520.



“... much of general practice is intangible and much depends on context. How do we measure communication, empathy, compassion, instinct, and experience? How do we measure the value of humour or demystification or reassurance?”

Questions of quality and *Duende*, Andrew Trevett, page 336

“... an extremely lucid, not very well known hunchback German philosopher of the Enlightenment, Lichtenberg...”

Bamforth's books, page 339

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Female genital mutilation

FEMALE genital mutilation (FGM), also known as female circumcision, is a deeply rooted tradition that needs to be addressed if the health needs of affected women and girls are to be met. The procedure has no health benefit.

The purpose of this article is to remind us of the problem. We wish to place FGM in its sociocultural context, and describe the procedure. It is hoped that this will improve the understanding of health professionals. We have a duty to encourage the abolition of this traditional practice from our shores.

The communities that practise FGM see it as an act of love and a rite of passage to womanhood. It is practised in 30 countries of Africa and the Middle East. In the United Kingdom, it is often seen among immigrants from Somalia, Eritrea, Mali, Sudan, Ethiopia, Sierra Leone, and Nigeria.

FGM is usually carried out on girls between the ages of five and twelve. A traditional birth attendant usually performs FGM. This is normally a local woman or a female member of the girl's family. There is no religious basis for the practice, either in The Koran or The Bible.

There are four types of FGM:

1. Excision of the prepuce with or without excision of part or all of the clitoris.
2. Excision of the clitoris with partial or total excision of the labia minora.
3. Excision of part or all of the external genitalia, and narrowing with sutures the vaginal opening. This is also known as infibulation.
4. Pricking, piercing or incision of the clitoris and/or labia. Can also include cauterising, scraping of tissue or introducing corrosive substances and herbs into the vagina with the express intention of narrowing the introitus.

These procedures are irreversible; the emotional and physical effects are

irreversible. However, reconstructive surgery may alleviate some of the distress.

In 1985, it was made illegal to perform FGM under the Prohibition of Female Circumcision Act 1985 and anyone found guilty of performing this operation is liable to a fine or imprisonment. At the present time, two GPs have been struck off the Medical Register for performing FGM, but no-one has been prosecuted under this Act.

The Children's Act 1989 states that everyone has a duty and responsibility to protect children. The welfare of the child is paramount.

It is believed that 1500 children in this country are at risk. If a child is thought to be at risk, we advise that the girl is referred to the African Well Woman's Clinic where expert help and advice is available.

With globalisation, most of our communities are multicultural. Understanding the cultural background of our patients requires knowledge of their beliefs and needs. This is never more obvious than with women who have suffered FGM. These girls and women must feel comfortable in the clinical encounter and the health professional requires great sensitivity and awareness.

You may never meet a woman who has undergone the ignominy of FGM; however if you do suspect FGM in the girl or woman you might ask: 'Are you closed?'. It is a phrase that is understood. Primary health care professionals and child health professionals need to be alert to problems in girls that suggest FGM. These children may develop urinary problems and later difficulties with menstruation. Be especially alert for girls aged six to eight years old who may be at risk of FGM; they are often being taken abroad for special holidays. The vacation does change their life, but not for the better!

**Jean Fuller
David Lewis**

References

1. Momoh C. *Female genital mutilation, also known as female circumcision: information for health professionals*. London: King's Fund, 2000.
2. All-Party Parliamentary Group on Population, Development and Reproductive Health. *Female genital mutilation survey report and analysis: report of the findings of research about the work of organisations in the UK and overseas on female genital mutilation*. London: HMSO, 2000. <http://www.appg-popdevrh.org.uk/FGM%20Report>

Further information and advice can be obtained from:

FORWARD
6th Floor, 40 Eastbourne Terrace, London W2 3QR.
Tel: 020 7725 2606
Fax: 020 7725 2796.
www.forward.dircon.co.uk

FORWARD is an international non-governmental organisation which promotes the good health of African women and girls through the elimination of human rights violations and gender discriminatory practices, such as FGM.

The African Well Woman Clinic
Central Middlesex Hospital, Acton Lane, Park Royal, London NW10 7NS.
Tel: 020 7955 2381.

Accepts referrals for girls and women at risk of FGM and can discuss options for reconstruction.

Out of Sight: An NSPCC report on child deaths from abuse 1973-2000, makes sickening reading. I challenge anyone, especially a parent, to read it without feeling horrified and angry in turn.

The horror strikes for many reasons. The contents of the report itself make a difficult read, but the 32-page appendix had me in tears. I remembered some of the names in the roll-call of children dead at the hands of their so-called carers, but not the full horror of their fates which seemed to cry out from the page, give us justice.

Two children are known to die in this way every week. There are probably more we don't know about. Many of these deaths are probably preventable and inaction has made the list of dead children longer than it should be.

The NSPCC has shown itself to be very media savvy in re-launching *Out of Sight* in the aftermath of the Anna Climbié case, as part of its Full Stop campaign. Have we not learned from past tragedy? Why was this

little girl tortured to death in a so-called civilised country? Not many column inches were devoted to it in the lay press. Why? And why are you reading this in the *British Journal of General Practice* and not a tabloid newspaper?

This is because the NSPCC has asked the College to endorse the report's recommendations (see box). Council voiced general support for the spirit of this report at its January meeting and a paper detailing specific ways the College can contribute to the work of the NSPCC went to CEC in February.

GPs, working as they do with families, are in a prime position not only to detect problems before they escalate but also to help prevent them. We can also join the NSPCC in lobbying for changes to be made that will enable us to learn from mistakes of the past before many more children die. Perhaps then, the dead will have their justice.

Tina Ambury

Out of Sight recommendations:

- Establish a national target aiming to halve child deaths where maltreatment is a contributory factor by 2010
- Establish independent multidisciplinary child death review teams (CDRT) on a statutory footing with a statutory requirement for professionals to comply with CDRT procedures, such as reporting all child deaths to a designated officer and contributing to any investigation or review of a child death which may be instigated
- Develop a UK-wide agreed protocol for the joint investigation of child deaths in consultation with all the agencies that participate in these procedures as part of the proposed national strategy
- There should be a commitment to ensuring multi-agency training takes place on a regular basis
- Public education on preventing child abuse should include programmes to increase parents' understanding
- The UK government should issue a Green Paper for widespread consultation on the legislative and policy changes required to implement the features of such a strategy

Useful websites ...

The NSPCC Full Stop Campaign
<http://www.nspcc.org.uk/fullstop/>

An NSPCC report on child deaths from abuse 1973-2000
<http://www.nspcc.org.uk/scripts/showprj.pl?story=4149&prj=406>

NORTH Tees PCG operates in an area of severe deprivation mixed with pockets of affluence in the North of England. It has a population of 182 000 patients and 82 GPs.

It was felt early in 2000 that revalidation could be seen as either a threat or an opportunity. If GPs saw it as a threat then they could leave practice early or, even worse, might be so unprepared for revalidation that they failed to be revalidated. Our PCG area cannot afford to lose more GPs, and indeed needs to attract more. We felt that if we took the opportunity of undertaking a revalidation pilot then it would prepare our GPs for the real thing and would help to demonstrate what we feel are high local standards, to help attract GPs to the area. We successfully bid for funding to the Postgraduate Institute at Newcastle University, and started our pilot in February 2000.

We invited all the GPs to a series of meetings to discuss the project and we had a good attendance of 30 to 35 GPs. We assessed their attitudes and feelings about revalidation, and developed a programme of work to design tools based on each of the areas of competence outlined in the GMC document *Good Medical Practice*. We involved the local Community Health Council, the lay member of the PCG, and the PCG chief executive and some of her staff as lay representatives.

We invited Sir Donald Irvine to speak to us. He emphasised the GMC's view that revalidation should be an integral part of normal practice. Evidence for revalidation should be collected without massive extra effort. He was challenged about the conflicting demands of management, service, patient care, and time. He agreed that these were serious concerns. He felt that the processes for revalidation had to be kept simple, but acknowledged that this might make them less robust than we had wanted.

At the end of the first year of the pilot, we reassessed the GPs' feelings about the revalidation, and there was a substantial improvement in confidence about it. The majority of the group now feel confident that they understand the process and they could manage it. There are still large anxieties about the time it will take and the resources that it will require. Most still do not believe it can be done as part of normal practice, and that it risks disrupting patient care. The tension between this potential disruption, and the need to demonstrate good medical practice to patients is a very real one and must not be minimised.

The next phase of the project is to train visitors to visit and assess the evidence that GPs and practices have been collecting to put in their portfolio. We expect to have this completed by the summer.

Rodger Thornham

'The examination and membership of the College should be seen as a valid and reliable assessment of good practice in all its forms and varieties, including ways of working that do not include being a principal in practice.'

Clark D. Examiner criteria for the MRCGP. *Br J Gen Pract* 2001; 51: 166-167.

Right to reply: MRCGP examiner criteria and the role of non-principals

On non-principals, sacred cows, and the MRCGP

IN February's *Journal*, Deborah Clark argued against the exclusion of non-principals from the panel of examiners for MRCGP and suggested that for the College to remain relevant to the increasing number of non-principals in the profession it must be accepting of the importance of the role and demonstrate this by drawing non-principal members into the examining fold. I suspect she is right in her basic premise that there is no absolute reason why non-principals could not become examiners for the MRCGP. Where I think she is wrong, however, is in the suggestion that the examination should not be testing a candidate's preparedness for the career option of a principal's post and I also can't help feeling that hers is a one-sided argument.

We all know that for a variety of reasons many doctors cannot, or do not, become principals on completing their training for general practice, but let's not lose sight of some obvious truths. Until, and unless, GPs abandon their GMS contracts and submit to a salaried service, it is GP principals who will continue to take responsibility for the delivery of most NHS primary care. Although non-principals play an important role as part-time assistants, locums, and retained doctors, their commitment is by definition less than that of the principal.

Non-principals are currently enjoying a high profile, and good luck to them, but many view with concern the steady erosion in the relative status and target salary offered to principals, without whom most non-principals would not have the option of working as they do.

So, let's not fight about it. I need non-principals in order to be a partner in a small practice and still take time away and, as things stand, they need me to hold a contract with the Health Authority, take responsibility for the practice management and cover Christmas Day. When it comes to the MRCGP examination, I believe it is designed to assess the candidate's ability to work independently as a principal, even if he or she subsequently chooses not to do so.

So, if there are non-principals out there with the necessary experience and who are prepared to commit at least 12-14 days a year to the examination, let's get together and try to change the rules. I'm sure non-principals could add breadth to the panel and their involvement might even force the College to find a way to pay them for some

of the work they will inevitably be asked to do in their own time on behalf of the examination.

James Heathcote

The Examiner's view ...

READERS of these pages will probably know (and if they don't, let me tell them) that the panel of MRCGP examiners is currently having a recruitment drive. After bottoming out a few years ago, applications to take the examination are rocketing - good news for the Treasurer, but an added strain on the panel and their partners in life and in practice. Believe me, we need more examiners.

It's been great, therefore, to have a number of non-principals expressing an interest in joining the panel, including Deborah Clark (February *Back Pages*). It was, however, salutary to find them reading the document 'Becoming an examiner for the MRCGP rather more closely than I had myself for sometime, and spotting the anomaly that would debar non-principals from serving in this capacity. Several of them wrote to me pointing this out, including Richard Fieldhouse, Chairman of the National Association of Non-Principals (NANP).

Dr Clark's preferred approach was to wonder, in these columns, what the reasons are for excluding non-principals from becoming examiners. Had she asked directly rather than rhetorically, I could have told her, as I told other enquirers, that she had spotted an anachronism dating back to the last revision of the examiner selection criteria, when to be a principal meant simply that you weren't a trainee, or a hospital doctor, or a full-time academic. In those days, non-principals as currently defined were all but non-existent. For most (though not all) of the reasons Dr Clark advances, I was easily persuaded that the panel would indeed benefit from including representatives from a valued and growing band of colleagues who elect to practise outwith the Principals List. By the time Dr Clark's letter appeared, proposals had already been drafted to bring this about which were presented to and, in principle accepted by, the Examination Board on 8 February 2001. Following discussion of the detail with Richard Fieldhouse, I can report that non-principals are now fully eligible for membership of the panel and will be selected on merit on the same basis as any other applicant. Dr Fieldhouse's latest

newsletter to the NANP included the following:

Was the rest of the profession still conspiring against us? Would nothing ever change around here? A slap on the wrist for the RCGP? Actually, no – the opposite in fact. Rather than an exciting conspiracy, this is all down to a simple historical oversight with the issue not having previously been aired. In response, the College pulled out all the stops, redrafted the regulations and have now put them in force – all within a two-week period. Now that's what we call progress!

That said, some important considerations remain. The majority of MRCGP candidates will still be looking to work as principals in unsupervised general practice with responsibility for both its clinical and non-clinical dimensions. The examination content is geared to this broad definition and candidates have the right to be assessed by examiners adequately versed in all its complexity. It remains unacceptable to the Examination Board for any examiner to lack familiarity, for instance, with the management of long-term problems or with the managerial and financial aspects of practice. Our revised selection criteria require testimony from referees that any potential examiner, principal or non-principal, has these competencies.

A penultimate point is that the Panel exists to serve the interests of the examination and thereby those of the patients we care for, not primarily, as Dr Clark asserts, to remain relevant to the interests of the increasing numbers of non-principals. Can we please remember which is the dog and which the tail?

On a final and personal note, may I enter a plea for people to be a little less ready to rush to adverse judgement on the skill and values of the College examiners? Almost without exception, those who make their acquaintance are impressed with their thoughtfulness, dedication, rigour, and devotion to high standards. The alacrity with which the panel has responded to this issue I think confirms the regard in which it deserves to be held.

If anyone out there would like to consider joining the panel, please contact Sandra Mackenzie in the Examinations Department at Princes Gate. Put your energy where your principles are.

Roger Neighbour
Convenor, Panel of Examiners

'Twas on a Monday morning that the CHI man came to call...

First the railways and the schools – now the NHS is to be modernised. One of our problems is that doctors keep sitting passively in their consulting rooms, seeing patients. If we are to improve services then this must change.

Fortunately, the DoH has suggested a new infrastructure of quangos, working smoothly and seamlessly together, that will force us doctors to get our act together and develop the paperwork in remarkable new directions. So your future working week (with acknowledgements to Flanders and Swan) may go something like this:

**'Twas on the Monday morning the CHI man came to call
Our MMRs were down the drain, It wasn't right at all
He fiddled with our database to try and find out why
He referred us to the HCC and said we'd have to try.
Chorus: Oh it's NICE to have lots more paperwork to do...**

**'Twas on the Tuesday morning the HCC came round
They brought modern evidence and said "look what we've found,
Your numbers are not up to scratch, you must put them all to rights"
He referred us on to PALS, after reading us our rights.
Chorus**

**'Twas on a Wednesday morning the PALS contingent came
While patients queued in corridors they played their little game
They couldn't reach their verdict without stakeholder support
So they had words with NCAA, while a locum held the fort.
Chorus**

**'Twas on the Thursday morning NCAA came along
With their audits and their guidelines and their cheery modern song
Waiting times went through the roof, it took no time at all
They referred me to the NIP while I went to my on call.
Chorus**

**'Twas on a Friday morning I saw the NIP
I couldn't get a locum, and the practice was at sea
The NIP they ticked me off as waiting times had soared
They referred me on to CHI, and to the Modernisation Board.
Chorus**

**On Saturday and Sunday they do no work at all,
So 'twas on the Monday morning that the CHI man came to call.**

Glossary: (remember where you heard it first!)

CHI – Commission for Health Improvement. Will police the implementation of NICE recommendations and National Service Frameworks.

HCC – Healthy Communities Collaborative. Will promote HDA guidelines to standardise practice.

NICE – National Institute for Clinical Excellence. Produces guidelines for treatment and audit that are voluntary but, as Sir Michael Rawlins says, It would be wise for a doctor to record why they were not following NICE guidelines. Consider yourself warned.

PALS – Patient Advocacy and Liaison Service. Will supersede CHCs in supporting complainants.

NCAA – National Clinical Assessment Authority. Will provide a rapid assessment of a doctor's performance, making recommendations for removal of doctors to the Health Authority.

NIP – National Independent Panel. Will adjudicate contested NHS changes. It comprises a lay/management majority.

Modernisation Board – Will oversee implementation of the NHS Plan.

And, more entertainingly, sources for **Flanders and Swan:**

Andalusia Editor Schreiner, Claus Paperback English ISBN: 1 57467013 1 Flanders & Swan Songbook Pp Paperback ISBN: 1 85909003 6 Flat-Pickers Guitar Guide Silverman.

<http://www.opengroup.com/books/index/bkixmuf.shtml>

Michael Flanders & Donald Swan. *At the Drop of a Hat*. \$10. V 508.

(live recording – UK mono LP) Angel (ANG.65042) VG/VG. ...

<http://www.moltenore.com/comedy.html>

Flanders & Swan, *More Excerpts From At the Drop of a Hat*, Parlophone GEP 8769 7

<http://thenorth.freesevers.com/soundtracksandmusicals.htm>

At the Drop of a Hat [IMPORT] from Goleta, CA USA

I first encountered Flanders and Swan on the LP version of this recording 40 years ago.

Loved it then, love it today ...

<http://www.amazon.com/exec/obidos/tg/stores/detail/-/music/B000026GPR/culturevulturene>

Postcards from the 21st Century Genomics — the latest

So we've done the genome — three billion bases all sorted. What happens next? The best way to find out is to take a look at the website where the publicly funded portion of the Human Genome Project is published (www.nature.com/genomics/human/papers). This has the talismanic significance of a true historical document — a website that rivals watching the Berlin Wall come down. It is also surprisingly moving in its generosity — such a large human endeavour donated for free — and awe-inspiring in its significance.

What happens next, of course, is even more hard work. The cost of sequencing DNA may be plummeting (down one hundredfold in 10 years) but the computational complexity of analysing such a mass of data is expanding exponentially in the opposite direction.

Then there are all the profound theoretical problems to be solved. The parts of the genome that actually code for proteins (the exons) are roughly the same size in flies, worms and humans; however, in humans, the size of the non-coding bits in between the introns — are about 10 times larger. Some 20 years after introns were first discovered we still do not have a clue what, if anything, all this apparently blank DNA actually does.

One certain effect of genomics will be to stoke the fires of the therapeutics revolution. Up to now, the pharmaceutical industry has only had a limited set of targets to shoot at — fewer than 500 molecular sites account for virtually all drugs on the market. The decoded genome is leading to a massive expansion in the number of possible targets, some of which will lead through to completely novel drugs. Recently, for example, a homologue of the gene responsible for the receptor 5-HT_{3A}, to which fluoxetine binds, was found by scanning the genome for similar sequences. This receptor, named 5-HT_{3B}, appears to have much greater effect on serotonin activity than the one which fluoxetine acts on. Similarly, a new class of receptors for the leucotriene pathway in asthma has just been announced.

Altogether, some 18 similar genes coding

for novel receptors related to existing drug targets have been discovered in the past few months. It is predicted that, overall, the number of potential targets for drugs will rise to around 10 000 as a direct consequence of the genome data.

Sooner rather than later this work will translate into new items on your prescription pad and it is these nuggets of gold that will drive the coming pharmaceutical Klondike. But just searching for the gold in the genome is to miss much of the point. Beyond the high peaks of the genome lies the serried heights of the transcriptome (the library of all human mRNA molecules) and beyond that of the proteome (the library of the three-dimensional shape of all human proteins). Elucidating the proteome holds the key to full control of our biology, for it is the proteome that enables us to understand what shape a particular enzyme or receptor is, what sort of drug might affect it, and how it interacts with all the other molecules in the body.

This journey from genome to proteome is a task sizeably larger than the genome project itself. However, not all journeys will be taken — the shape of health services in the next decades will be determined more by the search for profit than by science.

Some therapies are much more likely to be developed than others. Single gene disorders, for example, rarely affect large numbers of people. While a few of the commonest will be tackled, the rest are likely to languish as orphan treatments — theoretically capable of cure but damned to stay undeveloped by economics. This pariah state may be reinforced by the fact that gene therapy is likely to be a single treatment. Unlike drug therapy, the profits from gene therapy cannot be recouped over many years. Unless we develop new pricing mechanisms purchasers are likely to be put off by the apparently immense expense of each one-off treatment.

A bizarre alternative scenario is that the gene therapy would be kept deliberately incomplete, designed to work only with proprietary adjuvant oral therapy — which of course would have its own price tag. For these reasons the hot money for the first

Further reading/surfing

For an instant view of the original results of the genome project see the *Nature* site quoted above, or at Human Genome Central on www.ensembl.org/genome/central/

Danzon P, Towse A. The genomic revolution: is the real risk underinvestment rather than bankrupt health care systems? *J Health Serv Res Policy* 2000; 5: 253-255.

exons, introns, paralogs transcriptome, proteome

commercial application of gene therapy is on high profile, relatively common disorders, such as HIV and cancer, where a successful treatment is likely to lead to other insights and profits. The first human phase III trial for a gene therapy, for example, was undertaken for glioblastoma multiforme.

Single nucleotide polymorphisms (SNPs) represents a different problem. SNPs are the substitution of a single nucleotide in a gene leading to the presence of an unusual amino acid in the expressed protein and are responsible for the subtle changes in the target molecule.

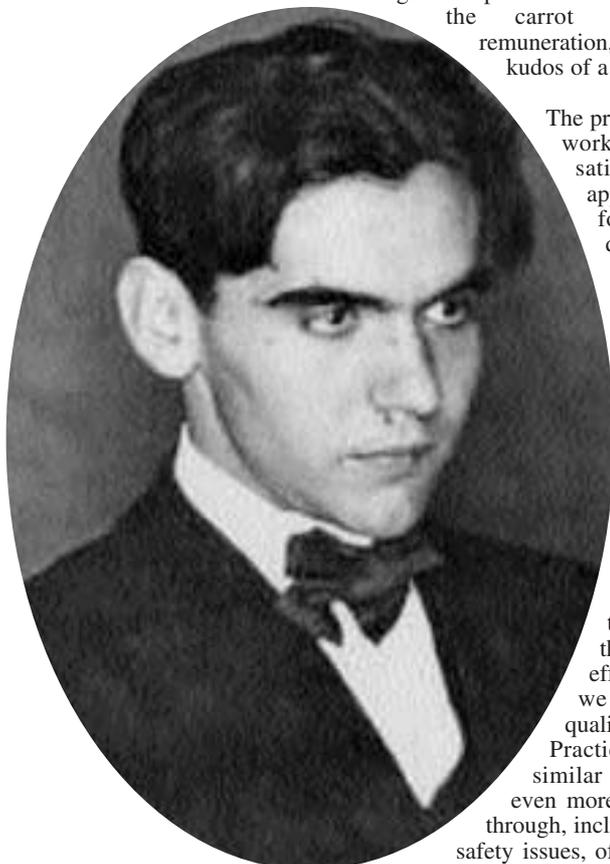
Some SNPs are inconsequential, others cause idiosyncratic differences in response to the therapy or disastrous side-effects. It is possible, for example, that response to statins is in part determined by the presence of SNPs in some sub-populations. Testing for SNPs in clinical situations will help focus therapies on those who are likely to benefit or prevent harm. Requesting SNP testing prior to therapy only makes economic sense if the savings from avoiding treatments for those who would not benefit exceed the cost of testing all patients. The economics of this are complex if SNP testing is cheap then purchasers and clinicians will both wish to use it to reduce dangerous or unnecessary care, leading in turn to fewer patients being treated and pressure for compensatory price increases. Expensive SNP testing may mean either less focused care (and increased risk) or increased overall costs.

Getting from data to effective solutions is always hard work and the human genome is no exception. As so often the science may be the easiest part. Devising new ways to price and pay for small volume, high cost orphan therapies or agreeing new ways to fund the coming cornucopia of new drugs are as essential to realising the benefits of our decoded genome as working out the intricacies of the proteome. Since most genomic innovations are being designed for primary care settings we had better have our act together too.

Paul Hodgkin
hodgkin@primarycarefutures.org

gues,
me, SNPs...

Federico Garc a Lorca (1898-1936)



THERE is a profusion of quality schemes and initiatives washing around the shores of general practice at the moment, ranging from the sustained quality scheme outlined in the Red Book to quality practice awards. Both schemes have the laudable objective of promoting high quality general practice the first offering the carrot of additional remuneration, the second the kudos of a QPA label.

The practice in which I work recently satisfied the appropriate criteria for a sustained quality assessment. We had channelled appropriate numbers of our patients through chronic disease clinics, kept records of our prescribing, and achieved the prescribed quantitative targets. All of this demonstrated efficiency, but had we demonstrated quality? The Quality Practice award is a similar scheme with even more hoops to jump through, including health and safety issues, office procedures, health promotion policies, and numerous other areas.

The implication of both schemes is that quality general practice is measurable and that the profession itself is in a position to define it. It assumes that surrogate markers can be used across the specialty for comparative purposes. Unfortunately, the same surrogate markers will be viewed by those outside the profession who may have less understanding of their limitations. This mechanistic approach ignores the argument that much of general practice is intangible and much depends on context. How do we measure communication, empathy, compassion, instinct, and experience? How do we measure the value of humour or demystification or reassurance? If our own quality schemes don't acknowledge these skills as an integral part of what we do, can we expect the general public or our political masters to think differently? True quality in medicine is about far more than measurable indicators. We should not diminish the importance of the humanist part of what we

do, simply because it is difficult to define.

In general practice the consumer has little choice of services. If we imagine a system where every practice in the UK was a private practice, where a true free market applied and patients shopped for their own services, how many of our quality indicators would be high on the agenda of our patients? Would many individuals be interested in whether we kept a chronic disease register, or whether or not we achieved 90% childhood immunisation or whether we achieved a high level of generic prescribing? It is shocking, but doubtful, that too many would see the welfare of our staff as a high priority to them either.

One starts to suspect that a large proportion of our quality indicators relate more to a public health agenda than to the agenda of the individual patient. Is it too Orwellian to extrapolate from this that a quality practice is one which can be seen to implement current government or local health board policy? It is not necessarily wrong that this is what we are doing but we should be explicit about it. We should explain, for example, why in the case of a vaccination programme, or generic prescribing, it is a good thing for the individual patient. The blasØ assumption that the greater good justifies the means and the lack of care taken to be open about such issues has been at the root of a number of recent medical own goals.

In the spirit of the new, non-patriarchal NHS, imagine a patient-driven quality scheme. Bill, a thirty-something executive has a sore back, which is preventing him from playing golf. Bill has few hang-ups about the health needs of the rest of the community. He wants his back sorted out. Bill wants a practice where he can make an appointment to see his own doctor the same day without him having to take time off work. He wants an evening surgery and, if it is difficult to get a baby sitter, he wants a visit at home. Bill thinks he needs an X-ray and he wants his doctor to organise this for him. He wants to be referred to see the specialist and so on.

As GPs, most of us would view many of Bill's wishes as unreasonable or unsubstantiated, but in whose eyes? Are Bill's indicators of quality any less valid than those we have created ourselves? We all know of colleagues who have been held in particularly high esteem because they have a lower threshold for referral to a specialist, are always happy to sign a Med 3 form or visit a coterie of patients regularly at home, even if the clinical indication for doing so might appear questionable. We begin to see that quality depends on context and that the indicators used to measure it

Recommended Reading

1. Eliot F. *The profession of medicine : a study of the sociology of applied knowledge*. Chicago, IL: University of Chicago Press, 1970.
2. Lorca FG. *Selected Poems*. Third edition. Translated by Merryn Williams. Northumberland: Bloodaxe Books 2000.
3. Gibson I. *Federico Garcia Lorca*. London: Faber & Faber, 1989

“Is it too fanciful to imagine that with *duende*, or whatever else we choose to call it, we can encourage, reassure, amuse, inspire, and see a patient leave the room feeling better than when they arrived?”

cannot be solely those chosen by the profession itself. I believe that creating a system which claims to measure quality is a dangerous precedent. I am not sufficient a nihilist to quibble with the merits of the majority of the items in the RCGP scheme but these same items are instinctive to most of us – keeping good records, prescribing generically and safely, immunising children, looking after our staff.

Where is the evidence base, however, to show that computerised records produce better patient care than handwritten records? Where is the evidence base to show that offering an appointment within 48 hours is more appropriate than 24, or 12, or six hours? Are our quantitative indicators equally appropriate to a single-handed practitioner working in an island inducement practice or a multi-partner training practice or a practitioner working in an area with high levels of deprivation? Do we accept that different jobs require different skills and different approaches? Do we want to find ourselves in league tables?

Clinicians apply a structured approach to diagnosis. From our earliest days at medical school we take histories and carry out examinations methodically. We collect our information and then apply a deductive approach to investigate and diagnose. Experience and instinct are two other skills we use which are harder to define, impossible to measure, unteachable, and potentially highly unreliable. Despite the lack of an evidence base for their value, few of us would be without them. Equally indefinable is the ability to form a rapport with a patient, to invoke confidence and inspire. Perhaps fancifully, I equate this with the intangible property of *duende* described by Lorca.

Federico Garc a Lorca is one of the greatest and most influential figures of Spanish

literature. He had a prolific output despite his premature death in 1936 when he was murdered by Fascist partisans during the Spanish civil war at the age of 38.

During the late 1920s and early 1930s, he undertook several lecture tours in America, Cuba, and Argentina. His most famous lecture was about what he called *duende*. It is impossible to find a precise translation, but, for Lorca, *duende* was the quality or essence that distinguishes great art from the mundane. He described it as a mysterious power which everyone feels but no philosopher can explain. In a modern context, we might go to hear a concert by a famous musician, technically brilliant, but lifeless, dead, it leaves us cold and deflated. On another occasion, perhaps even the following night, one might hear the same musician perform the same pieces of music and be inspired. We leave the concert uplifted, the world has become a better place, our problems have been lessened, our worries diminished.

The difference is that the musician performed with *duende*. I imagine *duende* as many things, as spirit, as soul, as belief, as conviction. I think there is something analogous in general practice. I don't think we always have *duende*; in fact, usually we don't and we can't produce it on demand any more than the musician can. I don't think we always need it, but there is an indefinable tool that allows us to connect with patients at a higher level.

When we see someone with a cold, we can do little to help them apart from offering vague symptomatic remedies to amuse them while nature takes its course. Is it too fanciful to imagine that with *duende*, or whatever else we choose to call it, we can encourage, reassure, amuse, inspire, and see a patient leave the room feeling better than when they arrived? It is medicine but it's not measurable, it is quality, but it can't be written down or listed or taught. It's not even the same thing for all of us but I imagine that most of us who have gone into general practice think that we sometimes have *duende*.

It is too simplistic to think of general practice solely in mechanistic terms, guidelines, knowledge, consultation skills, equipment, these are all useful tools but lifeless on their own. By all means let us embrace the good working practices listed in our quality schemes, surely most of us regard them as innate, but let us not lose sight of the fact that we at least should recognise that quality general practice is neither definable or quantifiable.

Andrew Trevett

¡No Hay Duende!

ANDREW Trevett is right that we need something more than the mundane and the measurable, to inject quality into general practice. We know what that something is when it happens, yet it is tantalising, elusive, and immeasurable. I would love to agree that Lorca's *duende* is the missing concept that captures the vital spark. However I fear it does not quite fit the bill.

In Andalusian mythology, the *duende* is a household goblin, gnome or elf, a somewhat mischievous spirit who enjoys creating irritating problems for the family. He is frequently the cause of minor physical illnesses. The Peruvian *duende* is also a troublesome creature, small, half-naked, with an enormous bloated stomach which he uses as a loud drum. Neither is really a first-choice role model for the general practitioner in search of quality!

Duende is also a free-standing concept in Spanish, denoting magical charm (presumably in direct derivation from the household goblin) or magnetism. In this sense, it is used by Andalusians to describe flamenco artists whose music or dance is especially inspired: ¡Hay Duende!. It is an essentially internal, individual condition, which can be observed but not directly shared by others.

Lorca expanded this version of the word, to articulate his conception of the creative energy of Spain.¹ He saw the *duende* as a force that is irrational and intuitive, spiritually connected to the earth, pantheistic and crucially concerned with death. It is something semi-mystical, which appears to take over the artist, and speak through them. It is not a creative muse, nor is it religious inspiration. It is something darker, containing a sense of anguish, a realisation of impermanence and loss.

Duende permeates Lorca's poetry:

*The guitar
begins its weeping.
The wineglasses of dawn
are shattered.
The guitar
begins its weeping.
It is useless
to hush it.
Impossible
to hush it.*

Lorca describes Spain as a bull's hide stretched out to dry – it has the shape of an animal hide, and a sacrificial animal at that. In this geographical symbol lies the deepest, most dazzling and complex part of the Spanish character.

Duende is exhilarating, and dangerous. By all means, let us bring inspiration and excitement into the consultation, though not so much that we scare our patients away. It may generate great empathy, but its inextricable connection with anguish and loss renders it tragically unsuited to the pursuit of quality in general practice.

Christopher Dowrick
Liverpool (and Granada)

1. Federico Garc a Lorca. *In Search of Duende*. (Edited and translated by Christopher Maurer.) New York: New Directions Bibelot, 1999.

I WAS visiting an old lady with abdominal pain and nausea the other night and decided to give her an injection of Stemetil. Aware of the possibility that she might die (we tend to visit patients who may die), and aware that she and the neighbour who was with her might have lost confidence in my benignity since the Shipman scandal, I adopted my new practice of carefully showing them the ampoule. Give me something to put me out, she said as she peered at the label. Well, I replied, this Stemetil will probably help you sleep a little.

That's not what she means, said her friend, with heavy emphasis.

Is there any overlap between the worries of the patients and those of the government, the media, our leaders, or even ourselves?

Michael Fitzpatrick has written a book of the first importance. He tackles head-on such contradictions in the role doctors and GPs in particular are currently expected to fill, and he draws clear and simple conclusions:

In the current climate any attempt to pursue political issues through medical practice is likely to have adverse consequences for patients, for doctors, and for the doctor patient relationship. In these circumstances the first responsibility of a doctor as a doctor is to provide medical treatment for individual patients ...

If the medical profession cannot defend its own integrity against government interference it is unlikely to make much headway in challenging the social causes of ill health. If doctors cannot take a stand against schemes of state-sponsored, medically-sanctioned coercion, then they risk finding themselves incapable of maintaining any sort of therapeutic relationship with their patients.

These are strong words, and they are spoken with the authority of a doctor working full-time in a difficult area of London. He writes well and clearly from his own experience. He also gives a remarkable account of the ideological background to the emergence and development of the National Health Service. He sets out clearly the stepwise and increasingly confident encroachment of politics into what was previously medical territory and addresses the extremely important question of whether this encroachment is wise.

Unfortunately the book is marred in the second chapter on Health Scares. His point is that the political view of medicine is dominated by our society's endemic inability to understand the scale of its risks, which is indeed true. But his list of health scares seems arbitrarily divided into major scares

HIV/AIDS, cot death, malignant moles, etc. and minor scares flesh eating bugs, bacterial resistance to antibiotics, nuclear radiation, etc. It is also incomplete he misses, for example, toxocara canis. But he fails to ask the real question; why our society flips straight from hysterical overreaction to fatuous reassurance, with nothing in between. And in classifying BSE and AIDS (even at the time of their first emergence) as scares he risks falling into the fatuous reassurance camp and looking dangerously irresponsible. It would be a tragedy if the kind of people who ought to be reading this book get no further, for there is powerful stuff ahead.

For example, his assault on the growing influence of anti-science and pseudo-science in medicine, particularly in the thoroughly dubious activity of health promotion, is rigorous and devastating. In this he follows Skrabanek, McCormick, and others in attacking the Achilles heel which the reigning orthodoxy has bared by officially espousing the supremacy of evidence. Fitzpatrick clearly understands what distinguishes real science.

Has health become the new religion?, he asks in another section, and makes a powerful, though admirably balanced, case that indeed it has. Gluttony, sloth, lust activities once proscribed as sinful are now regulated in the name of health. Healthy lifestyle is now seen as a duty to society. He quotes Fukuyama: We feel entitled to criticise another person's smoking habits, but not his or her religious beliefs or moral behaviour.

His attack on opportunistic screening was, for me, unanswerable. The day when we only measure, and certainly only record, patient's blood pressures when not clinically indicated unless they ask us to is surely overdue. And as for gratuitous health advice: Even when such advice is justified (which, as we have seen, it often is not) it is impertinent, especially when the recipient is ill. If the patient is a smoker and complains of a smoking-related illness, the last thing they need is a doctor telling them what they already know about the evils of smoking and the virtues of a healthy lifestyle.

Overtaking the tyranny of health involves challenging both the medicalisation of life and the politicisation of medicine. Medicine has been progressively subverted for non-medical ends. Doctors should stop trying to moralise their patients and concentrate on treating them. Then perhaps our patients will respect us again.

And so say all of us. Or is that too much to hope?

James Willis

Catholic Ethicists on HIV/AIDS Prevention

Edited by James F Keenan (with Jon D Fuller, Lisa Sowle Cahill, and Kevin Kelly)
Continuum, 2000
PB, 350pp, £15.99, 0 82641230 0

I HAVE a feeling that many of us have become somewhat complacent about AIDS. Apart from those working in areas of particularly high prevalence, such as parts of Edinburgh, most GPs have a relatively small number of patients with this diagnosis. I have a few such patients; I rarely see them because they attend a specialist centre for virtually all their medical needs and, by and large, they are doing well and lead productive lives.

This brilliantly edited and highly informative book paints an enormously different picture at the global level. First-hand accounts by those dealing with this problem in all five continents provide graphic evidence of the millions currently infected and affected by this virus. It would be unfortunate indeed if the rather daunting title of the book put off general readers with a social conscience, interested in the macro-rather than the micro-picture.

Some may consider the combination Catholic ethicist to be an oxymoron. The solution to any ethical dilemma inevitably involves the resolution of a tension between two conflicting ethical principles and, at face value, this is difficult for one working in a dogmatic and absolutist tradition in which compromise is discouraged, if not forbidden. As with most preconceptions this is based on stereotypical thinking, and is false. The two major moral problems for Catholics working in this field are condom distribution and needle exchange programmes, and convincing arguments are advanced justifying both programmes on both moral and empirical grounds.

In less than two decades HIV has surpassed both tuberculosis and malaria as the leading worldwide cause of death by infection. In contradistinction to other major epidemics in human history that particularly affect the elderly (e.g. the 1918 global influenzal epidemic) more than half of new HIV infections occur in persons under the age of 25 years. Life expectancy in some Sub Saharan African countries has been reduced by 20 years, and in some locations 40% of pregnant women are HIV positive. Worldwide, 1800 HIV positive babies are born daily. In Africa alone, two million people die each year of AIDS, and some 12 million children, many of whom themselves have died of AIDS, have been orphaned. The World Health Organisation estimated that by the year 2000 40 million people would be HIV positive. Ninety per cent of HIV infected persons around the world have no access to medical intervention. Surely we in the affluent first world must be shaken out of our complacency and both acknowledge and address this enormous problem?

The major revelation of this work is the

enormously complex cultural, social, economic and political factors involved in this epidemic. In a brilliant essay *Taking Culture Seriously*, Laurenti Magesa, a pastor in Tanzania, tells the story of Marcellus who died believing that evil people (*wachawi*, or witches) had caused his illness and eventual death. Consequently he was convinced that no Western medicine could help him in any way. In Africa, disease aetiology is considered to be an external (and most often malevolent human) agent. Similarly, sexual activity in African culture is geared towards procreation, preserving the individuals and clan's life-force. The use of condoms clashes violently with this mindset. The migratory labour system has had a major impact on the value systems throughout Sub Saharan Africa as men are unable to bring their families to their place of work, leading to the relatively common South African phenomenon of a man with two families, one at home and one in the city of work.

Women are often the principal victims of this situation: if in a relationship, they are socially disempowered and have no option but to submit to the sexual demands of an HIV positive partner; if not in a relationship, they often find themselves driven by economic imperatives into prostitution, and when they develop AIDS are abandoned whether they are wives, concubines or prostitutes. Poverty and inequality serve as the most virulent co-factors in the spread of HIV.

Our capacity to treat HIV-infected patients has expanded significantly over the past 20 years but the drugs alone cost \$12000-\$15000 per year for each patient and the per capita budget for all health care needs in many third world countries is \$10-\$15. In Egypt, and to my knowledge in other countries where Muslims constitute a majority of the population, AIDS is a taboo and its existence as an indigenous disease is denied. It is a foreign disease, contracted outside the country and no specific anti-HIV treatment is delivered.

It is clear that these complex cultural, political, and socioeconomic factors must be confronted and an understanding of them incorporated into seeking a mechanism of control. This is a challenging and unsettling book with the capacity to produce moral outrage not only in those with a specifically Catholic, or even Judaeo-Christian moral code, but to those who share the common humanity of John Donne: Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.

Benny Sweeney

bamforth s books

SINCE I'm presently lecturing on Goethe's *Faust* to a group of keen young Americans in Europe for a study semester, it strikes me that his largely unread poem is a good starting point (in Louis MacNeice's translation) for any attempt to understand why the paradigms keep shifting: they started shifting in a big way not in 1989 but 1789.

Faust can profitably be read in parallel with the novel of a 19-year-old freethinker, Mary Shelley, even if *Frankenstein* is embarrassingly implausible in the key matter of the monster's education. Hume, Rousseau, and Kant have into view, but Adam Smith's *Theory of moral sentiments* offers another kind of monster's education, in this case ours: how private vices make for public goods.

That altruism is a special invention for neutralising egoism emerges from another work of philosophy, *After virtue*, by Alasdair MacIntyre. Philosophers are seldom so lucid. One of the books he examines, Diderot's classic dialogue *Rameau's Nephew*, suggests that for all his talk of universal rational morality the Enlightenment emperor is absolutely starkers. That's why the voice from underground (the nephew) seems honest, or at least untainted by hypocrisy.

Such is the bleak message behind the best novel written by a doctor, CØline's *Journey to the end of the night*. At about the same time, in Paterson, New Jersey, blithely untroubled by questions of final ends, William Carlos Williams (*Collected poems*) was drafting poems about his patients on his prescription pads. And who can overlook the stories of a young doctor—the most subversive writer ever—who started out writing penny under the name Antosha Chekhonte: moral philosophy bored him silly too, but then he had Tolstoy. (*Anton Chekhov: Selected stories*).

Finally, another lucid, if not very well known hunchback German philosopher of the Enlightenment, Lichtenberg: his thoughts (*Aphorisms*) are exceedingly succinct, e.g. health is contagious. I've spent two years wondering how he reached that insight in 1790.

(And the one great author I'd like to add to Osler's canon—as a replacement for Oliver Wendell Holmes—is the vulgar churchman-lawyer-savant-physician-humanist Rabelais. Though you have to know the Old and New Testaments to get some of the jokes in *Gargantua and Pantagruel*.)

Iain Bamforth
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Radcliffe Medical Press have generously offered a prize for published contributors to 'Ten Books for Aspiring GPs'. So a copy of James Willis' *Friends in Low Places en route to Dr Bamforth...*

Clinical psychotherapy for health professionals**Edited by Harold Maxwell**

Whurr Publishers Ltd, 2000, PB, 207 pp, £19.50, 1 86156139 3

Psychotherapy and spirituality:**Crossing the line between therapy and religion****William West**

Sage, January 2000, PB, 224pp, £16.99, 0 7619 5874 6

Handbook of counselling and psychotherapy**Edited by Colin Feltham and Ian Horton**

Sage, London, 2000, PB, 788pp £24.99, 0 7619 5688 3

A GP offers witness to people's life stories and suffering, succour through the laying on of hands, and healing. Much of this latter may have little to do with biomedicine, but a great deal to do with the presence of the doctor: the reassuring confidence of one who knows about illness. The skills to be like this may be innate (the natural GP), or arise from experience; but many can be learned. A medical undergraduate noted last week (when observing as a writer in general practice), the healing effect on a patient when the GP murmured gently: Yes, it really does hurt, doesn't it?

Forget diagnosis and treatment. General practice is about helping ill people edge past their fears and doubts and deeper wounds.¹ Many skills needed for this can be learned from the theory and practice of psychotherapy. Balint brought this to the forefront of GP thinking, but we're still not there. These three books will help enormously.

An empathetic relationship between doctor

and patient is a vital element for healing. It needs to be supportive and offer insight, hope, unconditional positive regard, and respect (this is professional empathy rather than personal feelings towards the patient). The practitioner with psychotherapeutic skills will be able, to an extent, to read the patient: posture, facial expressions, gestures, clothing etc, as well as what they say; and know how to draw the patient out appropriately.

These are psychotherapeutic skills, but also creative writing ones – what my student (quoted above) was learning to her amazement and pleasure. Perhaps a GP is both doctor and writer: certainly patient and doctor together create a story.

Spirituality is a key component of our lives; yet it has taken over from sex as socially taboo. Much healing could result if health care staff could be open to supporting people spiritually. This is an extension of what David Loxtercamp meant when he said: For those of us who are devoted to general practice, our true business is serving the sick as a moral responsibility.¹ Psychotherapeutic skills and spiritual empathy can enable deep observation, understanding, and therapeutic contact with the patient in a short space of time.

Somatisation is high; depression is a complication of physical illness (in at least 20% of cases): 30% of GP consultations could be for psychological problems. Knowing how to detect and help these disorders can save time, distress, costly drugs, unnecessary referrals and heartsinks.

These books are a must for GPs and their counsellors (50% of practices have such invaluable staff). Harold Maxwell's is an inspiring easy-read introduction (despite an aggressive shooting target cover). The handbook is a first-class comprehensive reference book (too huge to read in the bath: you'd get pneumonia and tendonitis); it includes practical advice on such matters as codes of ethics, how to audit, as well as a fuss-free map through the confusing country of psychotherapy. William West guides us towards allowing the vital area of spirituality back into clinical practice.

Gillie Bolton

Reference

¹ Loxtercamp D. *BMJ* 2000; **321**: 1567-1569

Below: Caspar David Friedrich. Woman at a Window, 1822. Alte Nationalgalerie, Staatliche Museen zu Berlin. © Staatliche Museen zu Berlin. Photo: Joerg P. Anders

From *Spirit of the Age*, paintings from the Nationalgalerie in Berlin, showing at the National Gallery, London, until 13 May 2001. (£6, concs £4)



**The making of the English Patient:
A guide to sources for the social
history of medicine**

Joan Lane

Sutton, Stroud, Jan 2001

HB, 208pp, £25, 0-7509-2145-5

THIS book describes exactly what it says the making of the English patient. Where Scottish patients are mentioned, they are visitors, including Boswell, accompanied by Signor Gonorrhoea, which his armour (a condom) had failed to repel. Describing just the English experience gives an unusually parochial feel. The 1811 diary of a London bodysnatcher illustrates the extent to which, even then, our profession had assumed illegal access rights to human body parts. Joseph Naples was both resurrectionist and gravedigger from 1797 until the passing of the Anatomy Act, in 1831, when he acquired legitimate employment at St Thomas's dissecting room. It is hardly surprising then, that the *Carlisle Journal* recommended lacing coffins with explosives before burial, when even the gravedigger could not be trusted.

In restricting herself to the English, the author sacrifices reference to the unique Scottish contribution to medical education but this book is not about doctors, nor medical science, but about patients. There is little doubt about the considerable differences in past patient experience between the two countries; for example, the Tudor Poor Law, gave the English poor, uniquely among European countries, a statutory right to state support. Hence the chapter on pauper patients provides an early insight into the finances and individual experiences of state medicine, which would have been quite different in Scotland. The chilling removal of a working man suffering from the final stages of smallpox, immediately after morning service at Powick, Worcestershire and his subsequent transport 10 miles in a jolting cart to Tewkesbury, demonstrates that rationing by geography is not new.

The work is much more than the title suggests, being crammed with contemporary anecdote and narrative which makes the social history of patients jump from the page, through a collection of press extracts, letters, notes, accounts, diaries, cartoons, advertisements, and reports which have been gleaned by a professional historian from many sources, mostly county records offices. However, for the serious student, the book makes scant reference to the actual research process itself, and is far from being a toolkit. It would be better to have contained more information for the amateur on how to use primary sources effectively in record offices. A list of addresses of these institutions and other major sources of health and welfare records would also have been helpful. For most readers, however, the book will be an end in itself and one which is impossible to put down.

Jim Ford

MRCGP Preparation and Passing

Edited by John J Ferguson

Royal Society of Medicine Press,

September 2000

PB, 189pp, £17.50, 1 85315468 7

I REVIEWED this book with mixed feelings. Having taken a little longer than usual to pass the MRCGP, I didn't particularly want to revisit the subject; on the other hand, practical advice on preparing for and passing the MRCGP is not to be spurned.

This is the sort of book, with its promising title, that I would have borrowed from the local medical library eagerly hoping that it would provide the key to preparation and passing. Unfortunately it doesn't. Sorry about that.

There is a chapter on transcultural medicine (which I found interesting, but not always relevant) and one on consultation that reminds you what the real delight and challenge of being a GP is all about. This is appropriate because the first two-thirds of the book are a struggle to read, recounting as it does the structural reorganisation of primary care in the UK and the medical politics involved.

This section is also peppered with ugly almost-acronyms like HIMP, RAWP, PCG, PPA, PACT, PMS, DsPGE, HPE, and the really helpful LIFFH. Irritation is tempered by amusement on coming across ASTRO-PU in the section on prescribing, which sounds like it might be an intergalactic bowel motion thankfully, it's not.

The last third of the book concentrates on the practicalities of the examination itself, how it is marked, and what to expect on the day. There is little here that cannot be gleaned from the MRCGP Regulations handbook and the video consultation guide. Indeed the chapter on video consultations appears to be lifted straight from the video handbook, apart from the statement selection is all, which is something you realise eventually if you fail a few times (like I did).

Unfortunately, the overall impression given is that the average British GP is a bumbling outdated fool who is incapable of meeting the most basic needs of their patients. Quite apart from their clinical/patient advocate role, they are all without exception expected to be excellent negotiators, employers, business managers, statisticians, and organisers of health care for their localities.

There is an absolute gem, however, hidden in the text, and worthy of a read. John Schofield has written simply and enthusiastically and in plain English on the subject of audit. Indeed I found this so inspiring that I am looking forward to my next opportunity to do an audit, here in New Zealand. When the lemons ripen, maybe ...

Nancy Loader

graham worrall

The Cheesie Test

My colleagues and I are somewhat sceptical about the increasing prevalence of attention deficit hyperactivity disorder (ADHD), because when we look at some of the parents, whom we have known for years, we know that the poor kids never had a chance. However, as we are under increasing pressure to appropriately prescribe Ritalin, we have developed our own diagnostic test for ADHD the Cheesie test.

If, when you enter your office, the parent is seated but the child is rushing around, poking in cupboards, throwing things around, and there are crushed half-chewed Cheesies scattered widely underfoot, then the test is positive. This test is thought to have a very high positive predictive value for ADHD.

I'm more of a doubter than my colleagues. I want to see some good quality evidence. I am trying to persuade them to plan a controlled trial. After all, it shouldn't be too difficult to find a high-fat, high-carbohydrate, low flavour placebo from the junk-food section of the local supermarket!

I blame the provincial Minister of Fisheries. At a public meeting this gentleman, who has diabetes, announced that the symptoms of his peripheral neuropathy had been much relieved since he started taking seal oil capsules regularly. Since then, pharmacies across the province have experienced a run on the product, and several patients (with other complaints, not just diabetes) have admitted taking them and were now asking me what my opinion was of them. So, I decided to check with our friendly local pharmacist.

He confirmed that the colourless, odourless, flavourless capsules are a hot seller. This is not surprising, because at \$15.99 for a bottle of 100 capsules they're a lot cheaper than the latest ACE inhibitor. The label on the bottle gave no instructions as to what the product was used for. The ingredients were listed as lecithin, gelatin, alpha-tocopherol, and preservatives, but those must be the constituents of the capsule itself. There was no mention of which part of the seal provided the oil, but I assume that, as there was no mention of fat soluble vitamins, the animal's liver was not being used. I think that the oil is just rendered seal blubber, formerly used in oil lamps and cosmetics.

The bottle of seal oil sat there, not with the patent medicines, but on a shelf of food products such as Devil's Claw, Echinacea, St John's Wort, and Ginkgo Root. Food manufacturers do not have to follow the lengthy and expensive licensing process that true pharmaceuticals must follow. The pharmacist told me that they are all good sellers. He and I both knew that seal oil is not mentioned in our pharmacopoeias, and we agree that we should tell patients that we do not have any evidence that they do good, but

Foxes and rabbits

THE past is another country. Look at the medical journals of the 1950s and 1960s. Papers were written by one, or sometimes two authors, reporting a series of carefully remembered patients fitting a pattern matching the authors' preconceptions. Reviews were written by the great and good and friends of the editor and, arguably, determined the main thrust of medical practice.

Times have moved on, and mostly for the better. The bias of case-series has been recognised; the days of naked vested interest made transparent. The power (and the weaknesses) of randomised controlled trials have been acknowledged; the arrogance of unsupported authority deflated. But it is only mostly, not completely, for the better.

The past few years has seen an outbreak of political correctness and postmodern soul-searching in medical journals. No-one must be upset. There are no incorrect views, just different ones, but so readers know what has influenced those views authors admit competing interests. Sometimes this is essential. Many experts (a word that is now more of an insult than an accolade) are asked to write reviews about drugs but have received consulting or research fees from the drug companies. It offends against natural justice that an invited book reviewer be overcritical of a book in direct competition with one of their own. Readers need to know these things. A competing interest does not necessarily invalidate an opinion, but it admits the possibility.

Once we've started down the line of competing interests, though, where do we stop? There are interests other than commercial ones. Should an author admit to thinking someone a fool? What if a religious belief influences judgement? What if some life experience alters perception? What (for those who can remember February's news) if the author had dinner with the Lord Chancellor?

As humans are partly the sum of their experiences, but may be unaware of how those experiences affect their views, it follows that every author writes something of themselves into their writing and may not know it. Taken to extremes, medical authors would have to write their life stories at the end of every article, and when you look at some journals that seems to be happening. The editor of the *BMJ*, Richard Smith, wrote an editorial about animal experimentation and seemed to find it necessary to admit to his feeling upset when the family's pet rabbit was killed by a fox.

Maybe the admission was meant as wry humour. If so, it was misplaced for such a serious subject. If not, it was a fact too far. Let's leave competing interests to the blatant, and let readers judge our opinions as they see us, not as we see ourselves.

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Iain Bamforth is a writer and doctor based in Strasbourg. His account of Chekhov's journey to Sakhalin will appear in the June edition of the *BJGP*

Gillie Bolton's darker secrets are already familiar to readers of this column. Further details will be forthcoming at the General Practice Writers Association conference in Cumbria, in May, when she is a keynote speaker

Chris Dowrick's ideal life would be to spend half the year working as an academic GP in Liverpool, and the other half enjoying the sun, wine and mountains of Granada where he has a flat, thereby qualifying for that select group at the very top of the Deputy Editor's Christmas card list

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James Willis's latest book, *Friends in Low Places*, has just been published by Radcliffe Medical Press. More details at www.friendsinlowplaces.co.uk

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All of our contributors can be contacted via the Journal office

Foot and mouth

THE first I knew was a sign on a gate. Having abandoned our walk there and then, we were retreating back up the cold slushy track to the road when the farmer passed us by in his Land Rover. He scowled pointedly. I smiled fecklessly and muttered something along those lines too.

In a way I had quite mixed emotions about the whole foot and mouth thing in its first week or two. It felt a bit exciting, new, overblown, a strike for the de-industrialization of agriculture, an even bigger strike for vegetarianism though you'd be a bit of a vegetable for saying so in company right now. It didn't exactly feel good but it felt enough like someone else's problem that it didn't feel too bad either.

Then we had a blizzard that just about shut the area down for a week. We had a power cut that lasted two full days. Plenty of people went several days longer before their electricity supply was restored. The experience of those few days brought home a few key lessons to me. The first is that snow is no fun at all when you've got nowhere to thaw out afterwards. The second is how many clothes it takes before you can stop a baby from moving at all. The third is how totally, utterly dependent upon electricity we all are. In our climate at least, life without volts and amps is like, well, fields without farmers, swale without sheep, meadows without moo-cows.

I must confess that, electricity restored, I did go sledging. More than once, in fact. And felt little guilt too—sledging is too much about simple childish fun to allow it to be warped by guilt. But then afterwards, as the snow began to melt and normal life resumed, life rapidly became less simple. And that is how it has stayed.

Now guilt is a way of life. Analyse everything that has happened over the last two weeks and it seems that almost everything I have done has been risky in some way or other. I have been to farms, had dealings with other people, walked the dog where others go (where else is there than the beach?), taken my hat off in a high wind, eructated: breathed. How can it possibly be that I have not invisibly passed on this invisible disease?

Daily, as always, we check on our sheep. Recently though we dare not enter the field. We just drop some feed on the ground on the other side of the gate. Even so we wonder how they can avoid getting this plague that will see them slaughtered and us quarantined for weeks. The only reason we have sheep at all is because we couldn't stomach the idea of them becoming dog food so it would be a cruel irony for them to be shot at dawn while supposedly under our protection. We have given them names; Murdina is pregnant again this year. Too late to send them to Switzerland now.

As if foot and mouth itself were not complication enough, it also happens to be lambing season. This is a time when farmers don't have holidays and, commonly, don't even have much sleep. Most farmers these days bring their sheep in from the fields to lamb under cover and then rapidly return mothers and their progeny to the fields afterwards. This year it is illegal to move livestock without a licence and licences are not easy to get.

At the practice, we are contemplating becoming a third wave Personal Medical Services pilot site. For all the uncertainty we may feel about the risks of this enterprise you'd be a bit of a vegetable for saying so in company right now.