

# The Back Pages

## viewpoint

### Foot and Mouth Disease

**A**LTHOUGH Foot and Mouth Disease is not a disease of humans, the impact of the current epidemic on many of our patients will be incalculable. In the forthcoming months rural general practitioners and our primary care colleagues must work hard to minimise the risk of suicide and other human consequences of the outbreak.

How many readers have ever loved an animal – a pet dog or cat for example? How many of us have grieved the death of an animal, whether it has died naturally or been put down? Although, for some people, sheep and cattle are simply commodities to be traded around the country (and this is an important factor in the spread of the current outbreak), for most farmers and their families their animals are dear to them. Not only are herds of cattle and flocks of sheep a source of income but they are also part of the lives of farmers and their families, who work hard and endure extraordinary hours to ensure their welfare. Children are involved too – not least when they help to feed and look after pet lambs, which cannot be reared by their own mothers.

The current scale of death in the countryside is hard to imagine until you see and smell the piles of dead animals and massive funeral pyres. Healthy sheep, pigs, and goats are being killed to create a three kilometre firebreak around infected areas.

Many farmers have cut themselves off from the outside world in an attempt to avoid the virus reaching their farms. For some, the only reason they leave home is to come to the surgery, and even then only if it is absolutely necessary. Farmers do not want doctors, nurses or anyone else on their land for fear of contamination. If we do visit an infected farm, we must not visit another for at least three days. There are buckets of disinfectant at farm gates, shops, and surgery doors. We regularly spray our cars and our shoes and there are disinfectant-impregnated mats across the roads.

But our problems are minimal compared with those of our patients. At least we have an income. For virtually everyone else who is self-employed in the area, incomes have been slashed while expenses continue. It is not just the farmers and their suppliers who are affected, but those in the tourist trade and even window cleaners and tradesmen who cannot get on with their work. Children are struggling to get to school to prepare for GCSE and A-level examinations. Some schools are closed.

The pervading atmosphere of isolation, fear, anxiety, anger, and grief (the most powerful of human emotions) is unhealthy. People are at high risk of psychological illness, marital disharmony, and other dysfunctional relationships. Farmers and their families are already at higher risk of suicide than most. One thing I have learned as a GP is that it is not only depressed people who commit suicide. In Japan, *hara-kiri* is an honourable end. Some of our farmers and their families also see suicide as an acceptable solution to their perceived personal problems. Sadly, they often do not seek professional help.

Those of us who practice in rural areas have an important job to do to help our patients to cope with this outbreak of Foot and Mouth Disease and its consequences. Although, regrettably, some suicides are inevitable, we must attempt to reach out to those in distress to offer help and support where we can. We must also be aware of other sources of help and advice, such as churches and help lines (see below). Although we may not be able to measure the impact we will have, we can make a difference.

Jim Cox

#### Advice and guidance

##### Rural Stress Information Network

024 7641 2916  
(weekdays 8.30am 4.30pm)

#### Financial assistance

##### Royal Agricultural Benevolent Institution

01865 727888  
(9am 5pm, 4.30pm Fridays)

#### Practical support from farmers

##### Farm Crisis Network

07002 326326 (7pm 10pm daily)

#### Emotional help and support

##### The Samaritans

08457 909090 (24 hours)

#### 24-hour health advice

NHS Direct 0845 46 47



**“I recall the doctor who bypassed us on a ward round as she ‘was always bringing bad news to this family and I don’t want to see the mother cry again’.”**

*A positive death*  
Pippa Murray, page 424

**“When it comes to stopping poorly children from doing things they want to do, I am the great liberal.”**

*Making doctor better*  
James Willis, page 432

## contents

418	news
	Adolescent care in general practice, and southern India
420	belfast spring meeting ...plus farrell
422	postcards from the 21st century
	Children and confidentiality Rachel Hodgkin
424	essay
	A positive death Pippa Murray
426	digest and reflection
	Elwyn on risk, Heath on child poverty, Wright on depression, Paterson assessing two texts on palliative care, Davis in Eden ...plus worrall and neighbour's books
430	matters arising
	March Council
431	diary and
	goodman on <i>NHS Plan News</i>
432	our contributors and w illis

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## Measuring Adolescent Care in General Practice — Successes, Problems, and Pitfalls

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THE Adolescent Working Party of the Royal College of General Practitioners has long campaigned for improving the quality of primary care for adolescents, and one aspect of our work has been to promote and encourage research in this field. We felt that it would be timely to hold a meeting for those who have successfully conducted research (albeit with problems and pitfalls along the way!) in order to share our experiences with others who might be at an earlier stage in the process. The early stages of research can be daunting and we aimed to provide some inspiration and support for those starting out.

We were delighted to welcome 35 delegates to the symposium in November, at the Department of Paediatrics and Child Health, Royal Free Medical School. Delegates included academic and non-academic GPs, other primary care team members, and non-medical researchers. The day comprised a series of presentations followed by discussion around shared experiences, problems, and ideas. It seemed appropriate that the event should take place at the Royal Free, with its history of support for primary care research generally and research in adolescent health in particular a point well made by Professor Brent Taylor, who introduced the symposium. Further, it was here that the Working Party was first conceived.

The opening three speakers from Cardiff, Hertfordshire, and Nottingham mentioned similar problems surrounding funding and ethical issues. The particular legal and ethical dilemmas surrounding patients aged under 16 years were a subject of extensive debate, with helpful (and at times amusing) presentations expressing the frustrations sometimes encountered. Two of the speakers highlighted difficulties of recruiting teenagers to research studies.

In the ensuing small group discussions these themes were unpicked and groups also raised a whole range of other issues. These included: the time taken for new services to achieve word of mouth recognition in any locality; the difficulty in access to schools; the use of proxy measures for evaluation purposes the list seemed endless. However, the pervading lunchtime

atmosphere was still one of optimism in facing these challenges and finding support from others present on the day.

The afternoon changed tenor with presentations of pragmatic projects, exemplifying the phrase where there's a will there's a way. A prime example of this was the development and evaluation of a school-based teenage drop-in clinic in rural Hertfordshire. Initial, and continued, funding proved to be a major (but not insurmountable) obstacle, local medical politics gave the project intrigue, and it took 10 months for the final concept to become reality.

Continuing the evaluation theme, two speakers described their approaches to access effectiveness of educational interventions. The first, an educational package to promote confidentiality among general practices, highlighted the tension between the need for formal evaluation against the implicit assumption made by some agencies that such an intervention will automatically be effective. The second, an evaluation of a teaching video for medical students, demonstrated that pragmatism is always required when evaluating education-based interventions.

The final project presented was a qualitative study conducted by a group of GPs, who met to discuss difficult teenage consultations in Balint-style format. Practical difficulties of such soft research included the logistics of arranging group meetings on a continuing basis, problems of definition of terms and, most importantly, the difficulty of preparing manuscripts to report the finished project.

The day ended with an extended discussion by the whole group, indicating that delegates had indeed been encouraged, despite some of the more negative experiences shared during the day. It was particularly rewarding that the phrase: I had a patient provided obvious inspiration and motivation for all to continue the research ethos in this field.

**Lionel Jacobson  
Chris Donovan  
Dick Churchill**

*Adolescent Working Party of the Royal  
College of General Practitioners*

## Primary Care in the Deep South of India

At 6.30pm it was already almost dark and, with another 30 or so patients queuing outside, my translator was asking the villagers if anybody had a torch. One was often caught unawares here, as the sun sank at an alarmingly rapid rate and the mosquitoes and crickets emerged in a frenzy to take full opportunity of what little twilight there was.

A torch was found, and the mobile clinic continued to treat the silhouettes of patients returning from their daily labours. Their life was one of simple subsistence unimaginable to many in the West, and hard to believe by those visiting here who have the opportunity to look upon such scenes and wonder why patients at home find it difficult to wait so stoically.

Everybody knows someone who is suffering immensely, and is suffering in a way that, to me and to my training, is unacceptable. The hospitals at the far end of a day's walk don't really want to know; yet everyone seems so cheerful. The children run through the village and the fields to meet someone who, in truth, can't necessarily do a lot to help.

I receive tea and rice despite shaking my head and explaining that their problem can't be helped by the likes of me (unless they live where I do). Medicine in the state of Tamil Nadu depends on that great health determinant, wealth, and nobody here has much of that. Yet India itself is by no means the poorest country in the world.

In the rural villages the team of local

healthcare nurses visits fortnightly, this colony being one of 54 in a health project South of Kanchipuram. There is no visiting doctor or useful hospital follow-up. Access to villages is by bicycle or moped. The way out for residents is on foot or bullock cart. Workers are predominantly agricultural labourers. Their money is spent on food and shelter, with very little disposable income available for health care.

These untouchables remain truly untouched by modern medicine and its co-existing ease of access to care.

I was there to evaluate the project on behalf of a charity, which needed to know where their money is going. They could naturally do with a lot more, but what we would do with it is a somewhat harder question to answer.

Would we primarily tackle the common ailments, such as chest infections, diarrhoea or scabies, or more life-threatening illnesses, such as rheumatic fever, TB, heart disease or malaria? How do we tell a paddy worker earning 50p a day to take his child on a two-day trip to hospital for treatments possibly costing £20?

Surely, prevention and education is the key, but who will do this when nobody understands basic hygiene and there is nobody suitably qualified to sustain any teaching? How can we advise mothers to boil their water when they haven't enough fuel to cook food on their fires? What diet do we suggest for a patient with glycosuria who

eats the same food every day because that is what his field grows?

India is a challenge. It tests and it strains, but it also embraces. One becomes, in ways difficult to explain, content with what little advice one is able to give. We forget what is at home because we have to, for our own sake and the sake of these generous souls waiting patiently under the evening palms. (We have not forgotten either that the West, too has its own Third Worlds, that can test and taunt us just the same, where the chasm between surplus and despair is in many respects just as profound).

Tonight's turnout is remarkable. Word has spread that there is a doctor in town and a western doctor at that. Everyone has come for some magic. The wonder pill that will change their life.

If a Patient's Charter existed it would say that, above all, they just want to earn a living, be healthy enough to provide for their families, and to continue for a while longer, if possible. Their eyes implore me to give something from within myself, something they feel I may consider sharing, a secret they feel may be present, which can heal their pain. At once it is a privilege and a burden.

Such Indians need other Indians. Someone from their billion population. Ten weeks is long enough to accept just how unfortunate the world's poorest really are, but little time to make a difference. Medicines, equipment, and books may benefit. Money is always welcome. But India ultimately needs local people to deliver its care. Tamil people trained and speaking in Tamil. Local people providing the magic.

How can the haves help the have-nots? Perhaps by not giving out antibiotics in rural villages, or by explaining there is now a really wonderful drug (at the nearest hospital).

Some of the world's wealthiest citizens are Indian. The richest person in India could pay off their national debt several times over. The enormous wealth (and health) inequality is difficult to comprehend, let alone tolerate on our increasingly small planet.

We ourselves can add only a little and it would be naive to think otherwise. It may, however, be beneficial to contribute a small amount of what we do have, in order to show either this Third World or our own, the next steps forward for when those living in them are empowered sufficiently to act.

**Richard Davis**

*With thanks to the RCGP for its Bill Styles Memorial Award.*



## RCGP Spring Symposium, 2001

### Taking pride in primary care

The Waterfront Hall, Belfast

**W**HAT is the role of a Department of Conflict Resolution in the resolving of conflicts? was the question to the professor of said department. Does it actually help?

One could ask the same of general practice! he replied with a chuckle. Quite.

This exchange came at the end of the talk on the conflict in Northern Ireland, at the RCGP Spring Symposium held at the beginning of April in Belfast. Professor Dunn of the University of Ulster related the history of the modern troubles, finishing on an optimistic note. I wondered if many of the participants in our peace process have been through his department, or is there analogy with health promotion clinics the ones who attend aren't the ones who need to.

While I was at the conflict resolution talk, others were at a workshop on Practical Telemedicine. I avoided this on the grounds that I like going to the spring meeting and was rather afraid I might find that teleconferencing was the future, but I am assured by others that there is still scope for human contact. Like meeting people in the coffee queue; people who have problems different from mine. One Scottish chap described his tour of duty in the methadone clinic the day before 62 patients. I thought that must be for the whole county, but he said it was just his practice. Wow. I can hardly imagine that. We don't have a big opiate problem in Northern Ireland (drug dealers tend to be shot.)

Richard Smith, *BMJ* editor, almost got himself murdered by a gang of marauding women for accidentally suggesting that the diminishing social status of doctors was owing to the increase in females in the profession. I think he meant that, historically, our society esteems groups of women far less than groups of men, rather than that the women were bringing down

standards. At least I hope he did, for I want him to survive. His oratory is wonderful, and his command of a stage so impressive I always sit at the front to watch him. (I was a third-row-from-the-back man at medical school.) He addressed the topic The Future General Practitioner with enthusiasm and optimism for our branch of medicine, and reassured us that we wouldn't be squeezed out by increasing numbers of nurses on one side and specialists on the other.

This optimism was also evident in Mike Pringle's British Pride in Family Medicine, summarising the theme of the whole symposium. We are wonderful, and this is evidence-based now. There is a wider issue here. Why do only one per cent of GPs go to the spring meeting? One reason may be the low morale presently so widespread it is difficult to go to a meeting so full of drive, optimism, and pride when one is feeling sorry for oneself. The paradox is that attending such a meeting improves one's morale enormously. You can meet lots of others who have the same challenges as everyone else and still manage to practise with high levels of professionalism, intellect, and humour.

There was lots of humour at the Big Dinner. There was lots of wine too, and unfortunately I drank it. This made the challenge of appreciating the William Pickles Lecture all the more difficult. The Pickles Lecture is always on the intellectual side so approaching it with a sore head isn't a good idea, but I am delighted to report that this year's was so good it even overrode my hangover. Ann-Louise Kinmonth delivered a dissertation on The Doctor Hero or Villain? that was a *tour de force*. And her a woman too. Are you listening, Richard?

While some were revising Sports Medicine (Managing Common Injuries in Practice ankle injury while chasing difficult partner around the surgery?), I went off to



hear four views on The Quality Agenda in General Practice So did Sir Donald Irvine, and you can relax now, everyone, for Brian Patterson (Chairman of the General Practitioners Committee in Northern Ireland) told him what to do and the General Medical Council will now be a better place.

P.S. I also went to a workshop on Medical Writing. A strange lot, writers.

**Colum Farrelly**

**W**E are a wagon train crossing the plains of ignorance, Caritas and Scientia in the Conestogas. We are the frontier. We push on when we can, stop and fight when we must.

RCGP 2001 was, at least in the formal presentations, our professional/academic equivalent of taking a stand against the New Apaches; pulling the wagons into a tight circle, breaking out the Winchester, coolly drawing beads on the circling savages. Time, skill, values, are all on our side.

There was nothing actually new or outstanding in the lectures I heard; rather a sense of consolidation of values, of re-definition of our work, of emphasising how research has finally caught up with our innate needs to empathise, to share, to care with our patients in our joint struggles to ease the pain of being fully alive.

Ann-Louise Kinmonth gave her Wilfred Pickles lecture, The Doctor Hero or Villain. At first I was vaguely disappointed with it, partly because I heard similar from James McCormick 25 years ago but she demonstrated beautifully that everyone gains from bringing the patient into the loop. Lovely to know that I have been right all these years!

In the conversations between lectures all praise to the organisers both for the venue and the scheduling, which allowed loads of time and space for us to talk to each other we shared concerns, discussed radical personal changes, focused on how we will survive and prosper as individuals and caring professionals as the frontier changes daily.

I had a great time meeting old friends and making new ones, drinking a bit too much, and helping Liam Farrell with his seminar and with judging the writing competition entries. Topic? Killing patients with hatchets very uncontroversial stuff compared with running down cats in a Mercedes!

As for the circling Indians we re loaded and locked. Big Chief Running Blair wants to parlay, I hear. I guess we can go and listen...

**Declan Fox**

**I**N Belfast, on the Sunday, Professor Ann-Louise Kinmonth delivered a brilliant William Pickles lecture. The divided community of Northern Ireland has made heroes and villains of the same individuals: what better setting for an exploration of the ambiguities and paradoxes of this enduring dichotomy? In the year of the Shipman Inquiry, what better time?

With a general practitioner's awareness of the importance of context, Ann-Louise chose as her archetype a mythic hero who has become emblematic of struggle in Ireland Cœ Chulainn. Evoking his long training, his service to the state, and his inevitable mortality, she drew a subtle parallel with the making of the modern doctor. She emphasised humanity's enduring need for heroes, especially at times of crisis, and the extent to which patients reflect this need in making heroes of their doctors.

In 1911, Oliver Sheppard, an Ulster Protestant and a friend of Patrick Pearse, made a bronze statue of the Death of Cœ Chulainn. In 1935, the statue was placed in Dublin's General Post Office to commemorate those who died in the 1916 Easter Rising. In the more recent Troubles, the same image has been used by mural artists from both sides: by Republicans to symbolise their suffering at the hands of the British and by Loyalists to symbolise theirs at the hands of Republicans. Heroes, it seems, can transcend deep divisions of hatred and hostility.

Yet, notions of heroism and villainy always exaggerate and consistently favour image over reality, fiction over truth. Doctors set up to be heroes quickly become villains if they fail. As general practitioners, our aspiration to enter into constructive partnerships with our patients will only be realised if both doctors and patients can successfully resist the seduction of heroism and the closely related threat of villainy. In the history of medicine the heroism of doing to has been continually trumped by the gentler courage of being with. Effective partnerships rely on a commitment to being with and, once achieved, can provide the foundation for the production of those little increments of health which eventually outweigh interventions that are grandly heroic, but too often futile.

Those of us who were fortunate enough to be there will have the opportunity to reflect on the importance and subtlety of what we heard; those who were absent may never realise what they missed.

**Iona Heath**

**Liam Farrell**

**I**T'S that time of year. Love is in the air, the sap is rising, the bees are buzzing with sexual frustration, and at the RCGP Spring Meeting the Great and the Good have had their annual armslength congress with the Fat and the Ugly. Boy, do we love being patronised.

This year the meeting was in Belfast, a sign of the blossoming confidence in that fine city since the peace process began, and it proved to be an unadulterated triumph, an orgy of gargantuan proportions (in a good way).

There were really two agendas in progress the high-flying, ground-breaking innovative academic stuff, most of which I can barely remember except that the phrase GPs should be paid far more and work far less was curiously absent. I counted no less than six Professors and two Knights on the programme. Although there were plenty of GPs as well, because these guys have to have an audience, don't they? If a professor gives a lecture and there are no GPs there to listen to it, does he really make a noise?

Then there is the fringe meeting, a dark vibrant mysterious underground, the dangerous sleazy underbelly of College meetings where GPs transform into rabid streetgangs and beat each other up over the most minor differences of opinion on revalidation and clinical governance. Fortunately, injuries were minimal only a few damaged egos, two sprained pinkies and one badly bruised id, and seeing dawn harden into view through the mists of the mighty Lagan river was an unforgettable experience, only marginally diluted by the retching sounds coming from a certain faculty secretary who shall remain nameless.

The two festivals are bizarrely complementary: one runs from 9.00 am to 5.00 pm, and the other runs all the rest of the time. They are also not mutually exclusive some skilful GPs float dexterously between these two vastly different worlds, and I even saw Professor Mike Pringle, plumed and gorgeous, in the Hilton bar after midnight, gamely and implacably flogging the College ideals by hanging out with the lads and being one of the boys. Not a sight to forget, though you could try.

## Postcards from a New Century

### Children and confidentiality

This is the fourth article in our continuing series, *Postcards from a New Century*, commissioned and edited by Alec Logan (Deputy Editor, BJGP, London) and Paul Hodgkin (Primary Care Futures).

THE General Medical Council has issued new guidance on patients right to confidentiality which reaffirms the position that doctors will not disclose information about their patients without consent. This is because:

*'Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care'.<sup>1</sup>*

But should this duty of confidentiality hold for children? The answer seems to be yes, particularly where abused children are concerned. It is likely that there are a great many abused children who are not seeking help from doctors or other adults because they do not trust them.

The GMC is cautious about the circumstances in which doctors may breach confidences. Where children are competent, it says their confidences must be as respected in the same way as an adult's would be:

*'Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm'.*

One example of this is Where a disclosure may assist in the prevention, detection or prosecution of a serious crime. Serious crimes, in this context, will put someone at risk of death or serious harm and will usually be crimes against the person, such as abuse of children. As regards incompetent children, if attempts to persuade them to disclose fail, the doctor may disclose if you are convinced that it is essential, in their medical interests. But before doing so, the doctor must tell the patient and, where appropriate, seek and carefully consider the views of an advocate or carer.

This advice is ambiguous, perhaps unavoidably so, in its use of the words 'serious harm'. At first reading, one could perhaps assume that, as the sexual abuse of children is plainly seriously harmful and criminal, doctors should normally inform social services if they know or suspect a child is being abused, regardless of the child's competence. But would one so promptly breach the confidences of an adult? I recently asked a panel of doctors, genuinely not knowing how they would answer, whether they would feel obliged to inform the police if a woman patient disclosed that she had been raped and it was clear that the information would help the

police catch the rapist and prevent him from assaulting others. They agreed they would not breach her confidence, though they would try hard to persuade her to go to the police voluntarily. Nor would they breach the confidences of a woman stuck in a relationship where she was being continually assaulted.

Children, obviously, are much more vulnerable than adults; they are not free agents, able to choose where or how they live. And in the child protection world there are various doctrines. One of these is: Never tell children that you will keep their secrets. Another is: Keeping children's confidences is colluding with their abuser. But it is possible that this advice is, unfortunately, contributing to child abuse rather than preventing it.

The Economic and Social Research Council (ESRC) has recently funded research into aspects of children's lives. One study looked at how children dealt with problems and whom they turned to for help. Adults, in general, were not seen as reliable. The children feared that the adult would either trivialise their problems or would take control and insist on action against their will. Confidentiality was one of the central issues they raised, with friends perceived as more reliable than adults, particularly adult professionals.<sup>2</sup>

The truth of the ESRC's finding is reflected in three large surveys on child abuse undertaken in the 1990s, which suggests that two out of three children do not tell anyone about being abused at the time of the abuse. In total, 2362 cases were looked at either adults who were abused as children or social work cases of investigated abuse. A total of 65% of the victims did not confide in anyone, not even a relative or close friend, at the time the abuse was going on.<sup>3-5</sup>

Thus, one striking aspect of the North Wales child care scandal was the difficulty the investigators had in getting the young people to talk about what had happened. A guarantee of confidentiality was the only way the Waterhouse Inquiry could make headway in uncovering the truth.

A moment's reflection would explain children's reluctance to talk to adults about abuse, particularly sexual abuse. Imagine the difficulty you would have in telling a stranger about any aspect of your current sex life, let alone a deeply humiliating one; think of the embarrassment your patients suffer when raising sexual matters, even in the safe medical context of the doctor's surgery. Now add to that the fear and

#### Further Reading

1. General Medical Council. *Confidentiality: Protecting and providing information*. London: GMC, 2000.
2. Economic and Social Research Council. *Children 5-16 Research Briefing: Young people and welfare: negotiating pathways*. London: ESRC, December 2000.
3. Creighton SJ. *Voices from childhood: a survey of childhood experiences and attitudes to child rearing among adults in the United Kingdom*. London: NSPCC, 1995.
4. Palmer S, Brown R, Rae-Grant N, Loughlin J. Responding to children's disclosure of familial abuse: what survivors tell us. *J Child Welfare* 1999; **78**(2): 259-282.
5. Gibbons J, Conroy S, Bell C. *Operating the Child Protection system — A study of child protection practices in English local authorities*. London: HMSO, 1995.
6. *Hansard* 13 January 2000, vol 608, No. 22 cols 804-5.

uncertainty children must feel about what may happen if they make a disclosure: families destroyed, going into care, the abuser prosecuted, medical examinations, court hearings, and so forth. These children have already lost their personal integrity; now they may suffer a further invasion and total loss of control over their lives. And the sad truth is that abused children are caught between a rock and a hard place. If they disclose, the abuse may be halted but nothing else pleasant is likely to happen to them.

So we have a society where at least two-thirds of abused children are silent. Probably more, because surveys will only consider those cases in which child abuse has finally come to light. Do we not owe that silent majority a place where they can go to seek help about being abused in confidence? ChildLine, it is true, offers children very high levels of confidentiality, only breaching in dangerous/life-threatening situations which certainly do not automatically include all sexual abuse. But ChildLine has many more calls than it can answer and cannot provide children with personal, face-to-face help in the child's locality.

The past decade, however, has seen a patchy growth of independent advocates for children, particularly children in care or at risk of care. The scandals in the care system have led the Government into recognising these advocacy services, and that the statutory child protection services, necessary though they are, are not sufficient. A Department of Health Minister explained to Parliament what they were:

*'Advocacy is about effectively articulating the child's view, right or wrong. It is not about what the advocate thinks is best or in the child's welfare. Advocacy is grounded in Article 12 of the UN Convention on the Rights of the Child, which assures to children capable of forming their own views the right to express these views freely on all matters affecting them.'*<sup>6</sup>

In other words, advocates are not like social workers, charged with acting in the child's perceived best interests, but more like lawyers the servant, not the master, of the client. As part of this service they offer children a level of confidentiality which means that they will not automatically inform social services about sexual abuse. As with adults, there is no absolute confidentiality. If children lack competence then such confidences can be breached in their best interests and, like ChildLine, the confidences of competent children can be broken if necessary to protect

them or others in dangerous/life-threatening situations. Advocates must also be active, not passive, about disclosures of abuse: their role is not that of a counsellor or therapist; they are there to work with the child in sorting out the child's problems. For this reason, although most advocates I know have kept children's confidences about abuse for substantial periods of time, none has ever had to keep them for ever, because the child has always been persuaded to accept help in getting the abuse stopped. But it is only by giving children control over this process that they feel safe enough to seek help in the first place.

Advocacy services are currently translating their *ad hoc* practices into national standards, and are seeking to persuade other professionals of the need for their services. This sometimes proves difficult. We are hopeful that doctors, particularly GPs, would be supportive and see advocates as important supplements to not substitutes for statutory child protection services for children. As yet there has been little contact between doctors and advocates: any comments by readers on this article would be welcome.

Rachel Hodgkin

### Family matters



'Give me a boy till they are seven and I'll give you the man' said the old Jesuits. The psychological importance of those early formative years have long been recognised but it is becoming increasingly clear that pre-natal and early childhood factors also have quite unexpected physical consequences. Adverse events echo through the adult soma just as much as the psyche.

Ten years ago, Barker found that babies born small-for-dates were more likely to develop hypertension, coronary heart disease, and diabetes in later life. The intrauterine environment appears to permanently condition the physiology of the fetus to suit a particular nutritional state. An undernourished fetus prepares itself for a calorie-poor environment. When its expectation of frugality is confounded, the baby can no longer re-adjust its metabolism to plentitude leading, decades later, to atherosclerosis and insulin resistance. Sadly, the catch-up growth that small-for-dates babies achieve once born comes too late to reverse these abiding intrauterine and prenatal effects.

It is also clear that adverse childhood experiences are good predictors of later ill health. In one US study, responders were asked about seven adverse childhood experiences: physical, sexual or psychological abuse; violence against the mother; or living with someone who had been a substance abuser, mentally ill or in prison. Half the 9500 responders reported none of these factors. The remainder reported at least one, and usually more than one, adverse factor.

Perhaps not surprisingly, an unhappy childhood makes for an unhappy adult — those experiencing four or more of these adverse events had up to 10 times the risk of adult suicide, alcoholism or drug abuse, compared with those who had experienced none. More unexpectedly, an unhappy childhood also makes for a physically sick adult. Experience more than four factors as a child and you more than double your subsequent risk of CHD, stroke, chronic obstructive pulmonary disease, and cancer — an effect that was independent of economic and educational status.

We rightly spend billions on drug treatments for CHD and diabetes. Each new meta-analysis is imbued with the NICE-est of intentions. Yet the data about the long-term effects of intrauterine and childhood experience somehow passes us by. What would children's services in primary care look like if we took this body of evidence as seriously as, say, the prescribing of statins?

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## A Positive Death

It is now two years since my 15-year-old son died. Although I had known for some years that his life would not be long, his death came as a shock. There was nothing in my experience, and little in my culture, which prepared me for those heart-stopping moments of signing his death certificate, arranging his funeral, and standing by his coffin knowing I would never hold him again. At the same time, against all previous expectations, my son's death taught me that death, when viewed as an ordinary part of life, can be approached positively.

During his final medical crisis, my son was seen by many different professionals. I recall the doctor who bypassed us on a ward round as she was always bringing bad news to this family and I don't want to see the mother cry again. One consultant told me his condition was very grim while another, unable to acknowledge the severity of his condition, promised he would have my son better in no time with the use of a different medication (one which had failed to work in the past). These experiences contrast starkly with the consultant who, with tears in his eyes, spoke to me about the short time my son had left in this world and with the meticulous care given by the nurses who recognised he was dying.

When professionals were able to be honest and clear with me, both my son and I were supported. Acknowledging the situation enabled me to make appropriate decisions relating to his treatment and care. As a result I was enabled to support my son both physically and emotionally.

My son was perceived by many as being severely disabled, having learning difficulties, physical impairments, communication impairments, and a chronic medical condition. Like many, I had grown up with the idea that to be disabled is to be of lesser value, defective in some way. These ideas are especially powerful when impairment involves learning difficulties alongside communication impairment. Our culture reflects an unexpressed conviction that a real human being communicates through language. My son challenged such ideas and taught me that he had something of great value to offer to anyone choosing to be open to him – a lesson that is now re-affirmed in my work with other disabled children.

My son did not use speech or sign; he did not point to words, letters or objects; he did not use images or photographs to express his ideas. Unable to access expressive language in any of its many shapes and forms he communicated with his body.

For years I grappled with how much he understood the spoken word. In his early years I found myself being defensive about the level of his understanding. He understands a lot, I would state categorically, for surely not understanding relegated

him to the realms of the sub-human. Over the years he taught me that not being able to use language did not necessarily mean he was unable to understand language.

It was not until my son was about ten years old that I felt confident enough with the lessons he was teaching to drop my preconceived ideas about communication. Valuing my relationship with him, realising that he presented a radically different way of communicating, I reached a stage where I was able to comfortably say I don't know how much he understands. He took me to a point where I understood that being fully human does not depend on language. I had learnt, through immensely satisfying mutual communication, that we had much to give and learn from each other, without speech. Our very different ways of communicating were complementary and allowed a great trust to grow between us which enabled me to expand my horizons and allowed my son to be in control of his life.

It was in the last six weeks of his life that the power and subtlety of this communication became most apparent. He went into hospital after a week of frequent violent seizures. I had no idea we were entering the last phase of his life. I thought that he was simply going through a bad patch from which he would never fully recover, but to which we would adjust. Perhaps he would not weight-bear again, perhaps he would not smile again. I thought like this because that was the way in which his physical condition had deteriorated over the years – slowly and steadily. I thought he still had some years left to him before he would die.

I'll never really know how much he understood of what was happening to him during this time. I do know that the experience of his last six weeks was, in addition to being hard and distressing, agonisingly beautiful; that in spite of terrible physical suffering, he conducted himself with great courage and dignity so allowing family, friends, and professionals, to follow his example.

I wonder now if my son knew, before anyone else, that he was going to die. For someone so used to communicating through his body this would seem to be possible. During the week preceding his final admission he either would not or could not weight bear and refused to eat. Kim loved his food; even at times when he was very poorly he would almost always manage to eat something. Yet he now refused to eat. His movements slow and delicate, he responded forcefully and unequivocally when I put a teaspoon of something tempting to his lips. Pursing his lips together he would turn his head away from me, very definitely showing me he was not interested.

After a week the doctors began to talk about tube feeds. I found this hard to accept.

Although I had not yet realised my son's death was imminent, I knew that tube feeds marked an irreversible deterioration. The medics, while sympathetic, took a different view here was a child who needed tube feeding on a temporary basis to help him fight this crisis. I agreed with some trepidation.

I now think that perhaps I did understand, on some deep level, what Kim was saying. A few days after he was given tube feeds I was able to decide with confidence and ease that I did not want him put on a life support machine. At the time I thought I was making this decision in his best interests. I knew that if he went on a life support machine once it would only be a matter of time before it were to happen again and again. Now, two years after his death, I wonder if I found that decision so easy because I was in tune with what he wanted, because I was following out his wishes, conveyed to me through his body.

The decision made, I arranged to bring Kim home to live his death as opposed to sitting waiting for it amid the machines of intensive care. I saw my son visibly relax in the familiar sounds and smells of his own home. I saw him smile again, his first smile for many a long week, as he realised he was home to stay. I saw my daughter go through the same process. Finding a sisterly role was difficult in the confines of the hospital. Once home she could find her own place to play in her brother's death. With music, Christmas lights, and dancing she brought a cheer to his room that only a young person could do. Treasuring every minute we had, we laughed and talked and cried all three of us living his death together. Many of the professionals supporting us rose to the occasion and dropped their own fear of the death of a child to match the courage and dignity emanating from my son.

The mutual dance of communication between us went on. Listening to the way in which he breathed showed me if he was relaxed and happy or tense and unhappy. I remember when his very good friend and support worker came to visit him, bringing him a book as an early Christmas present. Sitting beside him she opened the parcel and started to read to him as she had done many times before. Almost immediately I noticed that Kim's breathing changed, became more laboured, less relaxed. I suggested she stop reading and sit with him, holding hands. Kim's breathing settled down immediately and they had their last half-hour together sharing a happy, companionable silence.

Heartrending decisions had to be made about his treatment when was the right time to stop the physiotherapy, increase morphine, stop suctioning, reduce the amount of times he was turned? None of these decisions were difficult to make. Following the communication given

through his breath I found I knew exactly when the time was right. The emotional agony of such decisions was lightened because I knew I was merely following him and in doing so making his life easier.

Watching my son so closely, I realised that it was as agonising for him to be leaving as it was for us to be losing him. I was aware of him holding on, well beyond the time when he could have died, as if he was easing himself into death for our benefit as well as for his own. It was as if we supported each other through the agony. The manner of his dying left us all, especially his close family, with a legacy that is difficult to ignore or discard. It does not feel a coincidence that the night before his death we were all ready, in a mysterious way, for his inevitable end. My daughter and I were emotionally and physically drained. He was weak beyond belief and although he seemed to have gone from us two days before he was still expressing preferences which could, if listened to carefully and respectfully, allow him to exercise control.

Through doing this my son left me with the greatest gift a bereaved mother could possibly have his perfect death. With immaculate timing, following a peaceful night when he was looked after by two nurses, he died peacefully and beautifully as I sat down beside him in the early morning light with a cup of tea. In that moment I was aware that the way in which he died contained all the ingredients required for living a life of courage, integrity and dignity that heartrending moment of death was also a precious moment of life.

In the early days following my son's death I became aware, for the first time, of how much death is a part of life. Relegating it to a different compartment simply makes both the process of dying and the grief that follows more difficult to bear. My son appeared to be willing to face his own death, giving those of us close to him the opportunity to do the same. Perceived by the world to be a burden, he brought these lessons about life and death to those of us lucky enough to be connected to him. Silently and gently he encouraged us to question our view of the world; silently and gently he gave us an example of human courage and dignity; it was not until the last breath left his body that his communication stopped.

Sadly my son is no longer beside me to teach me more of his mysterious ways. As time goes on and I find myself emerging from the initial devastating grief, I am becoming aware that his lessons have an infinite depth and the journey of discovery we embarked on together continues. The comfort I gain from knowing I can never leave his lessons behind is immeasurable.

Pippa Murray

TOO many in the air at any one time, balls or aeroplanes, and things get difficult to manage. It is salutary to read that most of the pioneering work on risk management has been done in the world of aviation, where errors, unlike those in juggling, lead to the loss of many lives. This second edition of *Clinical Risk Management* by Charles Vincent draws attention to this concept of overload both at the individual or organisational level. Time and again, and reminded me of a recent editorial that likened clinicians to hamsters running ever faster in revolving cages. It is a timely text that pulls together many contributions, from clinicians as well as researchers and managers. To find that risk management in medicine is at least a couple of decades behind the pace of the pioneers in aviation and oil exploration should alert us to the unfortunate faltering way in which clinical governance and revalidation are being implemented.

For me, the key chapters in this volume are by two psychologists, James Reason and Jenny Firth-Cozens, on understanding the human factors in adverse events and the role of teams and organisational culture on the management of risk respectively. This is not to downplay many other excellent chapters, but Reason's analysis of the categories of error gave me new insights into the differences between slips, lapses, and fumbles. These, he says, are execution failures, distinct in other words from mistakes, which he categorises as planning or problem-solving failures. A further analysis of slips and lapses is proposed at the levels of recognition, attention, memory, and selection. I mention these merely as an aperitif for the expertise on offer.

These definitional categorisations allow risk analysts to move beyond the culture of stonewalling, guilt, and recrimination that remains an all too commonplace reaction to error in clinical organisations. Reporting and, equally crucial, assessing the exact origin of the error, and then addressing it positively, is a sign of a mature system that has put quality control at the heart of its operations. Errors in clinical organisations, as elsewhere, are typically situated in a long history of management decisions and organisational processes. In general practice it could be about the latitude given to receptionists to decide on the urgency of patient requests or about the freedom to override the repeat prescribing reviews on a busy day. Failure to respond to an urgent house call may well have its roots in a latent failure created in a practice meeting 12 months earlier that enabled three of the six available clinicians to be unavailable on the same day. In other words, errors (or violations) have antecedents that deserve careful assessment, feedback, and movement towards an agreed systemic correction, more often than we realise. Firth-Cozens takes us further into this area by

discussing organisational learning and the cultural changes that facilitate this process. She quotes from the literature that is building up on what are called high reliability organisations (HROs) ones that are nearly error free despite working in hazardous fields. In addition to two processes that underlie organisational robustness to hazard preparedness and flexibility she notes how the research evidence from aviation (and marine technology) has emphasised the role of teamwork in ensuring high degrees of safety. It is not, however, a pink fluffy vision of teamwork where no clarity exists about roles, responsibilities, and accountabilities. Teams in HROs know how to play hardball, in distinct contrast to the primary care team (a misnomer in my view) that, in most places, defy even the simplest analysis of accountability. HROs have very clear leadership, inclusive communication systems, and regular briefings. Team members are encouraged to ask questions and challenge decisions with appropriate persistence until there is a clear resolution or decision. If conflicts occur, the focus remains on the issue and not on the individuals. Try that concept on a few senior partners in general practice.

Readers of the *BJGP* will want to know how relevant this text is to their own organisations. Rogers does an excellent review of the literature regarding risk management in general practice but finds it difficult to find any substantial depth to this potential research area. There is of course always audit, significant event auditing in particular, and retrospective analyses of deaths and complaints. There are organisational interventions being introduced, such as practice development and continuous quality improvement plans. But when it comes to research about how to create safe systems to manage multiple time-interrupted work-flow patterns and complex diagnostic uncertainties, with literally hundreds of diagnostic tests and repeat prescription requests per week that must be connected (without error) to individuals by a complex group of interdependent clerical and clinical professionals, the science of risk management in primary care has barely begun.

This volume is a good place to start. There are chapters on clinical pathways, investigation and analysis of clinical incidents, and advice on how to implement a risk management system in organisations, to name a few. Most of the work assumes that clinicians work in large secondary care organisations but, even so, it is not too hard to generalise the messages to the more horizontal (and challenging) management systems of general practice. For the practice that is serious about becoming a highly reliable organisation a HRO this book is essential reading.

*Glyn Elwyn*

## Poverty and Child Health (2nd Edition)

Nick Spencer

Radcliffe Medical Press, 2000  
PB, 368pp, £19.95, 1 85775477 8

## The People of the Abyss

Jack London

First published 1903; reprinted 2000 by Lawrence Hill & Co.  
PB, 319pp, £12.50, 1 55652167 7

IN the summer of 1902, Jack London set out to explore the living and working conditions of the poor in the East End of London. He was 26 years old and already familiar with poverty and hardship from his own childhood. He spent seven weeks talking to the people he met and living as they lived, and he wrote an account of what he saw and heard in *The People of the Abyss*, which was published in 1903. In the preface, he wrote: I took with me certain simple criteria with which to measure the life of the underworld. That which made for more life, more physical and spiritual health, was good; that which made for less life, which hurt, and dwarfed, and distorted life, was bad.

His overwhelming conclusion was that poverty, in all its dimensions, was bad. Nick Spencer agrees. The second edition of his invaluable book *Poverty and Child Health* was published 97 years after Jack London's and shows that, in the interim, everything and yet nothing has changed.

Those living in poverty in the East End of London today live longer and much less squalid and degraded lives than their antecedents. Yet their relative position remains the same. The lives of today's poor are still very significantly shorter than those of their more affluent neighbours; their children are born smaller, grow less tall, have more illness, and achieve less in school.

The great strength of Spencer's book is the way he sets the current situation firmly within its historical and geographical context. The determinants and the outcomes of child poverty are both historical and global, both within the confines of a single life course and on the broader societal level. Poverty in childhood casts a very long shadow and Spencer shows both how the seeds of today's East End poverty were sown in London's Abyss, and how much the experience of poverty in London in 1903 parallels that in the slums of the developing world today.

Throughout the almost 100 years separating the two books, two conflicting explanations have been advanced to account the persistence of the social class gradient in health outcomes. Behavioural explanations place the responsibility firmly on the poor themselves by citing differentials in health-related behaviours, particularly smoking and diet. Structural explanations place the responsibility more distally, within the structure of a society that leaves people with little or no control over their life circumstances. Spencer lays out the

evidence in support of the latter with consummate clarity. To give just one example, in 1988 families dependent on state benefit had on average two to three pence per 100 kcal to spend on food for children in order to reach recommended daily calorie requirements. Tomatoes cost 70 pence per 100 kcal, oranges 25 pence, and even potatoes cost six pence. The only way to stick rigidly to under three pence per 100 kcal is to adopt the diet of bread and dripping and sweetened tea so familiar to Jack London's *The People of the Abyss*. Time and again poor people can be shown making choices which are appropriate to their constrained circumstances.

The second edition of Spencer's book is updated to take account of the change of attitude to poverty and health under the Labour government elected in 1997. Welcoming the change, Spencer remains concerned that too many of the proposed interventions continue the time-honoured, but victim-blaming, focus on the health behaviours of poor people, while too little is done to reverse the gross inequalities in income distribution which blossomed to such a frightening extent under the previous administration.

The book finishes with an Appendix, added just before publication to include details from UNICEF's League Table of Child Poverty in Rich Nations, which was published in June 2000. One of the key findings was that child poverty could be eliminated in the UK with the investment of 0.48% of the GNP.

Responding to the suffering of the People of the Abyss, Jack London formulated his Golden Rule: The application of the Golden Rule determines that East London is an unfit place in which to live. Where you would not have your own babe live, and develop, and gather to itself knowledge of life and the things of life, is not a fit place for the babes of other men to live, and develop, and gather to themselves knowledge of life and the things of life. It is a simple thing, this Golden Rule, and all that is required. Political economy and the survival of the fittest can go hang if they say otherwise. What is not good enough for you is not good enough for other men, and there's no more to be said.

If more people could be convinced of the validity of this Golden Rule, the political will to fund the elimination of child poverty would necessarily follow to the enduring benefit of us all.

Iona Heath

## neighbour s books

THE practice of medicine being an elaborate metaphor for virtually everything else, you the aspiring physician must confront the trickiest question known to man. No, not How shall I lead my life?, nor even How shall I prepare for death? (though we'll deal with these presently). You should rather begin each day by asking yourself How seriously shall I take things? and, for guidance, by reading any and every *Peanuts* cartoon Charles M Schulz ever drew.

Then, while still well-intentioned, turn to the *Meditations* of Marcus Aurelius, from whom you may learn what compassion, courage, and hugeness of spirit can flow from the habit of unflinching self-examination. However, lest preoccupied with noble intent you fall prey to the snares of lesser men, learn from *The Prince* of Machiavelli how the petty politicking of the said lesser men can must, if your integrity is to survive be outsmarted. Doctors can be dangerous, you see, in systematic and subtle ways. Ivan Illich's *Medical Nemesis* (The medical establishment has become a major threat to health) will provoke you to healthy indignation, while Peter Shaffer's horse-blinding play *Equus* will alert you to the perils of good intentions.

By now you may need reminding, not of what you are against, but of what you are for. I hope you are for the humanity, the lyricism, the elegance, and the personal values that imbue E M Forster's *Howards End*. Only connect the prose and the passion, he entreats. Truth is not halfway between anything.

Humbled by Forster's demonstration that language has greater therapeutic power than the scalpel or the pharmacopoeia, you will delight in Roget's *Thesaurus*. Thus sensitised, you might aspire to no nobler epitaph for a doctor than Henry Reed's lines in *Lessons of the War*, that when we meet our end, it may be said that we tackled wherever we could, that battle-fit we lived, and though defeated, not without glory fought.

Gulp. Time to read Oscar London's essays on how to be the world's best doctor, *Kill as few patients as possible*. Rule 5: Keep eye contact with your receptionist. Rule 26: Don't try to feel a breast lump over the telephone.

But as the day draws to its darkling, flippancy and erudition must yield alike to mystery. Twenty-five centuries ago Lao Tzu, in the *Tao Te Ching*, prised from his meditations this wisdom: The ten thousand things rise and fall without cease. Work is done, then forgotten. Therefore it lasts forever.

Roger Neighbour

**Depression: social and economic timebomb**  
**Edited by Ann Davidson and Andre Tylee**  
BMJ Books, 2001  
PB, 206pp, £19.95, 0 72791573 8

**T**HE striking title of this book derives from the prediction that under the most conservative estimates... the burden of depressive disorders will increase by at least 50% by 2020. Hard-pressed GPs may be forgiven for agreeing in the book with John Cox, President of the Royal College of Psychiatrists, that depression is not a timebomb waiting to explode, for it has already exploded! Based on papers presented at an international conference organised by the World Health Organization, this publication tackles mainly social, economic, and service issues rather than day-to-day care. It is not a clinical textbook.

Throughout the book, and in the foreword by the Prime Minister, there is much emphasis on social and environmental factors. Concern is expressed over the impact of depression, not only on the health and quality of life of patients but of families: on average five other individuals are severely affected by one person's serious depression.

A clear and readable overview of depression in general practice is given by Sir Denis Pereira Gray, who reminds us of the importance of the patient's view of the illness. In no other branch of medicine is the perception of the patient of greater significance. Managing depression may be difficult for the doctor but it is also particularly rewarding professionally. Andre Tylee, Professor of Primary Care and Mental Health, tackles disease management and the improvement of mental health skills

in the primary care team. Didactic training packages are simpler and cheaper than problem-based courses but results from innovative projects by enthusiasts are often not replicated in less committed practices. I heartily support his plea for added funds for evaluation.

A thoughtful patient's view is given by Richard Hornsby, a true insider, as I have lived with this very difficult illness for many years. He sees depression as a horrible and terrifying journey undertaken alone and often with inadequate information. Challenging statements that GPs have the time or are expert in diagnosing and treating depression, he urges GPs to become better trained and be better listeners to the narratives of their patients.

Conference proceedings are often of uneven quality since they lack prior peer review and selection. I like to judge for myself the authority with which individual authors speak and the weight that can be attached to their pronouncements. The list of contributors, their qualifications and current post is helpful (though not completely accurate) but why, oh why, not repeat this information at the beginning of chapters to ease endless page turning?

Despite multi-authorship this book is, on the whole, readable and easily digested. It is a valuable overview of concepts in depressive illness and issues in improving management.

*Alastair Wright*

### The Eden Project



## Palliative care in the home

Derek Doyle and David Jeffrey

Oxford University Press 2000, PB, 163 pp, £27.50, 0 19263227 2

## Cancer from cure to care

David Jeffrey

Midwives Press, 2000, PB, 150 pp, £15.95, 1 89850783 X

**T**WO books written by specialists to inform generalists the hackles rise. However, what is critical to these works is that the authors spent many years in general practice before moving into specialist palliative care. They are, therefore, in that ideal position (inhabited by regrettably few specialists) of genuinely having knowledge of primary care, understanding its peculiarities, weaknesses and, most importantly, its strengths. Fundamentally, they are aware of what primary care is capable of. It is interesting, and surprising, to find that one author has been concerned in two such different approaches.

*Palliative Care in the Home* is a vademecum. It is a clear no-nonsense text. As well as discussing the more obvious topics, such as symptom relief and communication, there are illuminating chapters dealing with home or hospice?, spiritual and religious issues, and professional stress. The chapter covering the last 24 hours is particularly useful. We are encouraged to appraise not only our knowledge and skills, but also the values and beliefs that underpin how, and why, we care. The core primary care is given its place, as is that unique aspect of general practice, our pre-morbid knowledge of the patient. The stage zero of cancer care, before the cancer journey begins.

By the end of the book I was more informed, had a clearer understanding of the various issues, was reassured, and, most importantly

felt enabled to do a better job. A book like this translates well to other medical situations; it is not just about delivering good palliative care at home, it's about delivering good care, full stop.

*Cancer: From Cure to Care* is both thoughtful and thought-provoking. It addresses the difficulties and uncertainties faced by GPs working with patients suffering from cancer, based on a qualitative study of the cancer care experiences of 11 GPs.

Their dilemmas are grouped and the different categories discussed. All the usual suspects are there: defining when palliative care begins, stopping active cancer treatment, communication, symptom control, continuity of care, prolonged dying, effective teamwork, and stress. The book closes with a discussion on current decision-making frameworks and a new model is proposed.

The text is liberally and powerfully annotated with original responses, followed by a detailed examination of the issues raised. We are privileged to be privy to these doctors' thoughts and uncertainties. Like good case discussion this is intense, emotive, and real.

The final words define the components needed for the provision of appropriate care: competence, compassion, and commitment. That should guarantee a place in any practice library.

*Euan Paterson*

**I**T is rare for expensive new undertakings to be greeted with universal acclaim by the media, but in the case of the Eden Project this has been the case. It is the world's biggest greenhouse, and houses a phenomenal array of tropical plants; however, there is even more to it than this. It combines many ingredients which seem to have ensured success. First, it is not in London. The capital of the universe came up with the Millennium Dome unpretentious little St Austell boasts the Eden Project. Ha ha!

Eden is one man's dream. Thank you, Tim Smith, for showing us that determination and vision can still triumph. It isn't finished yet the Mediterranean biome may seem sparse and arid now, but it won't in six months time.

Being able to visit during construction and watch it evolve through its early stages makes one appreciate the mammoth undertaking it is and gives us such a spark of

loyalty that we have supported it from the start.

We realise that the natural world is evolving. By comparison, conventional gardens look artificially twee and complete. The tone is worthy but not pious. The whole arena is a celebration of plants and the natural world.

Our visit leaves us in awe of the environment and mindful of our place in it without being crushed by guilt. The accent is on useful plants, ones which provide us with food, clothing, cosmetics, medicines, and building materials. Seeing coffee, liquorice, and guava cements our appreciation of them. Parading them all under one astonishing roof also makes for a fabulous work of art.

The project is a perfect synthesis of science (the architecture!), nature (everywhere you look), and humanity (feel that for yourself). There must be lessons for the practice of medicine in this.

*Alan Davis*

graham worrall

## Between jobs

**N**EWFOUNDLAND has long had the highest unemployment rate in Canada. You can forget all you might have heard about the 4% unemployment in the US, and the overall Canadian rate of 7%. In this province, the rate is about 20% and in rural areas like ours it can go as high as 40%, especially in the winter, when fishing and logging cannot take place.

This means that the polite and diplomatic rural physician does not ask the patient, 'Are you off work because of this?', but 'Are you working at the moment?' Furthermore, one learns that to be out of work and receiving unemployment insurance payments from the government is far more socially acceptable than getting social assistance payments although for lower-paid workers the cash amounts are not that much different. If you're on social assistance, it's in some way your own fault, if you're receiving unemployment money, it's the fault of the employer or the government.

Consequently, a large proportion of our rural population regularly only works for a part of the year, often as little as a third of it. People are accustomed to a seasonal lifestyle, with reduced income for part of the year.

However, being unemployed in rural Newfoundland is not too bad, most of the time. The lifestyle is rather like that of a country gentleman in Scotland. Land is cheap or free (most land is owned by the Crown, and anyone can claim a building lot for almost nothing); you build your own house, using lumber you cut yourself from the coniferous forests (paradoxically, we, the poorest province in Canada, have the highest rate of owner-occupied housing); you have a small boat for fishing at sea or on any of the ponds and rivers (for a tiny licence fee); you own a snowmobile or all-terrain vehicle for winter travel to your cottage in the woods; and you can hunt ducks, rabbits, bear, moose, and caribou in season. You have time to tend your garden, and you certainly are able to do all the repairs on your own house.

Of course, people who are unemployed do still, despite their country pursuits, have a lot of time on their hands, and time to dwell on their health. This results in quite a lot of folk in our waiting room who probably wouldn't be there (or not there so often) if they had regular work.

This becomes apparent when a local facility for building off-shore oil rigs hires workers by the hundred for a new mega-project, or in the summer when the fish-processing plants are working around the clock. Many of our regular patients disappear for a few months. Of course, they come back, as regular as the seasons, when they are laid off work again in the Fall.

**Health and Social Care Bill: Patient Confidentiality Provisions**

The College has registered our concern already on this aspect of the Bill. The relevant clause started out as Clause 59 and is currently numbered 67. We have briefed many organisations and a number of peers on the issues twice and feel that this has been influential in at least achieving some modest amendments to the provisions.

The clause allows the Secretary of State to make regulations, both to withhold data in regard to the NHS, and also to direct disclosure of patient identifiable information. The one significant concession the Government has made is to ensure that there is an advisory group which will advise on the making of regulations and the principles under which the disclosures might be made. This does not go anywhere near far enough and we would hope that the provision may be deferred, allowing our concerns to be considered or, at the very least, significant amendments to be made. We are working with other organisations, not least the BMA, on this matter. Our press release and briefing can be found on the College website.

**Patients' Liaison Group and Council Executive Committee**

Council was pleased to agree a change whereby the Chairman of the Patients Liaison Group (currently Mrs Eileen Hutton) will in future take an observer role on our Council Executive Committee. Given the valuable work that the Patients Liaison Group does, and can do, this is a very welcome initiative.

**Packaging of Drugs**

Our Patients Liaison Group has produced a very significant report on the difficulties that there are with the packaging of drugs. Too many packages are insufficiently distinguished from others which can lead to confusion, with potential dire results for patients. The issues concern the loss of identifying text when blister packs are broken open, the covering up of Braille on the outside of packages and, in some cases, labels that are difficult to read, especially for those with vision impairment. Council was very supportive of the proposal to raise this as an issue which we will be taking forward with vigour, and adding other points which could usefully be advanced with the paper.

**UK Council, March**

**Foot and Mouth Disease**

Council heard of the grave situation which faces many rural GPs as a result of the spread of foot and mouth disease. The practical problems that GPs encounter in reaching patients, observing the vital restrictions on movements, coping with increased incidence of stress, and suicide threats in rural communities was a reminder to us all of the vital work done by GPs day to day, which goes unheard and unseen by many. Council was very willing to be associated with the words of support and understanding that our Chairman Mike Pringle voiced and which were echoed and given real meaning by Dr Jim Cox, who chairs our Rural Task Force.

**Northern Ireland**

Council approved new Bye-Laws for the Northern Ireland Faculty that will enable it to operate in a manner much closer to our existing Scottish and Welsh Councils. The eventual aim, pending constitutional reform, is that there should be a Northern Ireland Council.

**College Budget 2001–2002**

Council approved the budget proposals, allowing key College activities and projects to go forward in the coming year. We shall be able to attract significant new funding for certain projects.

We also discussed a general review of College activities. This will look at different methods of delivering certain services (include the option of contracting out) and will first consider the Courses and Conferences, followed by Publications.

**Modernisation of the NHS: emerging themes from the three countries**

There are some distinct differences between England, Scotland, and Wales for example, social care (as distinct from medical care) will be free at the point of delivery in Scotland, whereas that will not be the case in England and Wales. Is there any benefit in putting pressure to improve matters in other parts of the UK? We will continue to monitor these divergences and point out where the problems arise.

**Senior House Officer (SHO) Review**

We had a series of papers before Council: the first was from the SHO Modernisation Technical Group and the College's response; the second and third were both from Has Joshi, Chairman of our Education Network, on the future of SHO training and on the future of Vocational Training; and a fourth from the Joint Committee on Postgraduate Training for General Practice on modernising the SHO grade.

We have already given evidence to the Review which is moving forward very quickly. The role of primary care is vital here and there are possibilities that we may achieve some gains (at least in the longer

term) to make GP training much more fit for purpose. However, we will need to ensure that service needs do not again outweigh the training needs and that rigidity of rotations is replaced by more flexible programmes.

**Workforce**

The issue of GP workforce continues to feature in the headlines, not least because of the efforts of this College, together with the General Practitioner Committee. The Government seems to have accepted that its plans for the increases in the number of GPs fall short of what is required and this has precipitated a downturn in morale, judging by recent results from a Scottish GPC survey of GPs, which was also before Council. We intend to press our points whenever the opportunity arises and via the Primary Care Workforce Review the results of which we now await.

**Revalidation, Appraisal, and Accredited Professional Development (APD)**

Mike Pringle brought forward a brief paper summarising the position on appraisal, APD, and revalidation.

The GPC is negotiating with the Department of Health on annual appraisal for GPs in England. No conclusions have been reached so far but the key points on the negotiation at present are the balance between the NHS, the professional and lay involvement, and the question of resources.

As to revalidation itself, the College's working group is continuing to meet, the GMC is conducting its pilots, and we are being kept informed of progress. We expect the GMC meeting in May to decide whether revalidation will proceed. If so, the timetable will be to introduce revalidation in January 2002, allowing a year for the first cohort of GPs to prepare for revalidation in January 2003. Once the GMC has finalised the third edition of *Good Medical Practice*, we will be fully able to align our *Good Medical Practice for General Practitioners* with the new version and circulate that to all GPs. That should lead to producing a final version of our methodology for revalidation for general practice. The Chairman, Mike Pringle, is considering how best to keep everyone informed on these crucial matters.

**National Clinical Assessment Authority (NCAA)**

The main issue for the College appears to be how the NCAA will work in primary care and this will be an opportunity for us to influence the agenda and clarify the relationship between the new Authority and the GMC. We support procedures for monitoring and improvement of poor performance in general practice but we need to ensure that the profession, as well as the public, can have confidence in them.

**Accredited Professional Development**

This is a very exciting development for the

College which has now reached a very advanced stage and is subject to a second round of pilots. APD is a voluntary system for GPs allowing them to demonstrate explicitly their commitment to lifelong learning, which will measure quality improvement and will be accredited for a period of five years.

The huge benefit that those undertaking APD will see is not only that their learning needs are being constructed and developed appropriately but that following APD will enable doctors to provide the evidence required for revalidation. That linkage has been supported in principle by the GMC but we still have to go through a number of stages to ensure that the detailed points are satisfied. We are now at the point where the convenor for APD can be advertised shortly and the administrative and managerial support can be introduced. The terms on which APD will be offered will give added benefit to members of the College and we are hoping to attract significant sponsorship for this new programme.

#### GMC Structure and Education Role

We are very keen to see an early conclusion to the GMC governance review as this will allow the GMC to move forward. It is equally important for the future of professionally-led regulation that the new structures are right and do command confidence from key stake holders.

Views were clearly divided in Council regarding the paper on the GMC's role in doctor education. Some favoured the GMC having a much stronger role, others that this should rest with the new Medical Education Standards Board. There was agreement on the following principles: the medical education continuum should be much more closely integrated whichever body has the lead; education should be based on good medical practice; it should be independent; and the roles of the Royal Colleges should not be diluted.

The GMC is also consulting on major changes to its Fitness to Practise procedures and I will be asking a number of members to assist me in preparing our response in the normal way.

#### Next Council Meeting

Friday 8 June 2001, Princes Gate, London.

**Maureen Baker**

*Honorary Secretary, UK Council*

#### Best of the Rest...

**Shipman Inquiry; National Service Frameworks; GPs with a special interest; NICE**

A full transcript is available on-line at [www.honsec@rcgp.org.uk](mailto:www.honsec@rcgp.org.uk) and feedback

#### NHS Plan News

As if we didn't have enough to read, the weekly *BMA News* has replaced *BMA News Review*. With all the originality of an advertising campaign for deodorant, the publication was described as heralding a new and exciting era. Depending on the results of the negotiations for the new consultant contract, the era could be more than exciting: frustrating, demoralising, or depressing may be more apt descriptions. Dr Ian Bogle, BMA Council Chairman, could be right that the BMA needs a weekly forum for members' opinions; or it could be that the publishers wish to decrease the influence of *Hospital Doctor*, *Pulse* and the other freely circulated weekly medical newspapers.

Whatever, I am more likely to take notice of the revamped *BMA News* than I do of the outpourings of *NHS Plan News*. This unbiased, independent publication comes from the DoH, produced by your taxes and enabling the government to tell us how far we are along the road to modernisation. It will appear quarterly.

There are few things more depressing than someone telling you how wonderful things are when you can see all around you that they are not. I'm not saying that all is terrible, and that there is no hope. But eight glossy pages of propaganda on sometimes ill-considered schemes stick in the craw. Rhetoric and platitudes drip off every page.

It's not as if we are alone in our failings. A US Academy of Sciences commission has just reported on the US health system. It doesn't work. It doesn't work to the extent that the commission says it is irreparable and needs a complete reorganisation. Not only does the US have all the problems we have, such as postcode prescribing, but it also has the distortions of commercial medicine: best practice is ignored if it means patients will be charged less.

Canada's was thought to be the best system. But they are now short of nurses. Where are they to hire them from? Right first time: the United Kingdom (*Toronto Metro*, 29 September, 2000).

*NHS Plan News* is being distributed to staff through dispensers in the workplace or via managers. The only dispensers that it fits for won't take glossy paper and managers are too busy completing their recently ordered, compulsory searching of all hospital premises for body parts to think of doing a paper round. Yes, by order of Those Upstairs, every single Trust in the country appointed a team of three to unlock every cupboard and cabinet by 6 April. Signed declarations are not enough.

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Dick Churchill is a GP in Chilwell, Nottingham

Jim Cox is a GP in Caldbeck, Cumbria  
Alan Davis is a GP in St Austell, Cornwall  
Richard Davis is the winner of the 1999 Bill Styles Award and is a GP in Jesmond, Newcastle upon Tyne

Chris Donovan is a retired GP based in London

Glyn Elwyn is senior lecturer in general practice, University of Wales College of Medicine, Llanedeyrn Health Centre, Cardiff <http://www.glynelwyn.net/index.html> — unfortunately no glamorous pics. His academic interests focus on referral analysis and shared decision making between patients and doctors

Iona Heath is a GP in Caversham Group Practice, London, and chairs the RCGP Ethics Committee. Like James Willis and Salisbury Cathedral, she is a National Monument

Rachel Hodgkin is an advisor to the Advocacy Consortium and a consultant on children's rights. She can be contacted on [rachel.hodgkin@btinternet.com](mailto:rachel.hodgkin@btinternet.com)

Lionel Jacobson is an honorary lecturer at the University of Wales College of Medicine, Division of General Practice.

Pippa Murray is the parent of two children — her son Kim and her daughter Jessie, who is now at college. Pippa is a co-founder of Parents with Attitude, an organisation that has published two collections of stories looking at the family experience of living in a disabling world from a human rights perspective. Since Kim's death, Pippa has been studying for a PhD looking into issues of family support. She is also working as a freelance researcher and consultant.

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A regular column by Roger Neighbour starts in these pages later this year. He is Convenor of the RCGP Examination Board  
Euan Paterson relaxes by buying very expensive motor cars on line, to the highest specification, then bails out just before hitting the 'I Agree' button. He is a GP in Govan, Glasgow

James Willis' latest book, *Friends in Low Places* (Radcliffe, 2001) will be reviewed in a forthcoming issue of the *BJGP*. For a sneak preview look at

[www.friendsinlowplaces.co.uk](http://www.friendsinlowplaces.co.uk)

Alastair Wright edited the *BJGP* for an unusually long time. He received the George Abercrombie Medal, for medical writing, at last November's RCGP AGM

#### *Our Belfast reporters...*

Liam Farrell practises in Crossmaglen in Northern Ireland. Declan Fox qualified in 1979, left hospital medicine because he liked talking to patients, left the NHS because he got depressed, went to Canada to start over and is now in search of sanity, quality of life and job satisfaction. He lives in Newtown Stewart, Northern Ireland and works in O'Leary, Prince Edward Island — the ultimate in commuting! And Colum Farrell, like every GP in Ireland, has a surname beginning with 'F'. He works in Derry

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

### Making Docor Better

I have never been able to understand the fascination that so many children have for the paraphernalia of medicine. I think it is thoroughly morbid for them to have plastic doctor-sets with ugly, non-functioning stethoscopes and auroscopes and patella hammers. You've got one like that at home, Harrison, haven't you? Mum will say as I produce my stethoscope. I want to ask why Harrison hasn't got an assault rifle, or a yo-yo, or something healthier. (Of course he has.)

My earliest memories of the doctor's surgery, apart from the smell, are of instruments. Shiny instruments, neatly regimented into rows on white cloth-covered trays. Symbols of office more potent than diplomas on the walls.

Syringes and needles, wonderfully large. Especially the needles. Lined up from the steriliser. That's the one we keep for the bad boys, said one GP, pointing to a needle so enormous that I have never been able to imagine a plausible use for it. Though God knows I've tried. At the time I rewarded his joke with a gallant laugh, but the image has never left me. Along with the musty, antiseptic smell of his room, and of him.

When I became a doctor I didn't want my child patients to have that image of me. That is one reason I have always kept my instruments as far as possible out of sight, in cupboards and drawers. And why I manage to almost never let a child see a needle. Not difficult when you think it's important.

Not that my childhood doctors were unkind. I have no recollection of the myringotomy I am supposed to have had on the kitchen table. Nor of the stitches when I fell against the angle iron of the Morrison table (a contraption optimistically intended to protect the family from air raids) although I still bear the scar. Oh but it really is serious this time. My mother remembers saying, as she arrived with bleeding me at our GP's door, and the enormous reassurance of his arm around her shoulder. I have certainly tried to be a doctor like that.

The only real resentment I remember is having been stopped from doing things for reasons that now seem silly. After the stitches in the back of my head, for example, just before setting off for our annual seaside holiday. The sharp pricks were perfectly OK, but not the ridiculous turban bandage, and being prevented for a week from going into the sea and using the inner-tube raft we had planned for so long with our father, when the seawater would have done (as I now know, and then guessed) the stitches nothing but good. And when I got acute otitis media in Daytona Beach, Florida, I didn't mind the pain of the Triplopen injection anything like as much as being prevented from using, even once, the wonderful trampoline in the motel garden. So when it comes to stopping poorly children from doing things they want to do, I am the great liberal.

It's a mixed memory, but it has had a more profound effect than anything else on the kind of doctor I try to be for children. I don't want to smell of antiseptic, to be associated with macabre instruments, to be a forbiddener of nice things, but I do want to be warm, caring, gentle, kind, and reassuring.

A mother once told me that when her little girl was feeling ill she asked to be taken to Docor Better NICE Docor Better. You can keep your check-boxes; that's the kind of audit that counts with me.