The Back Pages

viewpoint

The ballot result is safely in — but what now?

GRASS root doctors have always looked to the General Practitioner Committee to lead them to a promised land in the words of one member, the troops are anxious for the generals to go over the top. The results of its recent ballot will therefore give all parties cause to think deeply about the future of British family practice as there is now a clear demonstration that the GPC has wide support,[1] countering the Government's propaganda that it is merely a fringe element of militant malcontents.

Ironically, the current GPC negotiators have a cerebral and constructive approach that is now far more in tune with the public mood, leading to doctors' unjustified feeling that their leaders prefer 'jaw jaw' to 'war war'. However, recent negotiations with the Department of Health have been perversely obstructed[2] and, as the frustrations of ordinary doctors deepened, it was the troops that finally forced the issue. The new government will forget this at its peril.

Despite missing voting papers, some misunderstanding of the question posed, and the famed inability of doctors to give an unqualified answer to *any* question, the result of the ballot is compelling. On average, 66% of GPs voted; 86% positively. This means that over 50% of all UK GPs would consider resignation from their present NHS contracts as a last resort. The GPC have therefore been given a clear mandate but the problems are far clearer than the solutions, which will differ for doctors practising in different circumstances, in different areas of the UK.

Government ministers protest that they were already negotiating a new contract. Their officials, however, seemed to be more intent on splitting the profession by promoting a contract for personal medical services that undermines the GPC's universal negotiating rights, perhaps eventually threatening the independent contractor status.

Workforce problems were addressed by offers of golden hellos and goodbyes that would have been comical if they were not so insulting.[3,4] Skill mix and proposals for more practice nurses would have been reasonable if nursing was not suffering an even greater crisis of recruitment and retention. Doctors' mistrust has only been deepened by knee-jerk responses to issues over access to primary care, with many millions profligately spent on walk-in centres and NHS Direct/NHS24, at the expense of an already deficient primary care infrastructure. In the short to medium term, workforce and workload issues seem insoluble, so what can the incoming government do, besides recognising that any solution cannot be resource-neutral?

Ministers must recognise that while a few retired doctors might be enticed back or delay retirement temporarily, any necessary increase in GPs will be long delayed. There is, therefore, an urgent need for more clerical staff to free the hands of doctors and nurses, both of whom are hard pressed clinically and who constantly struggle with too much paperwork. Nurses who have more clinical time can free that of doctors to do what they do best and, in turn, better trained GPs can relieve much of the increasing burden on hospitals. All this needs to be delivered in buildings fit for purpose, with open access to clinical tests and support and with modern information technology.

Government must recognise that change that is merely politically expedient demoralises and demotivates those who remain in the job. It must recognise that it is far more productive to direct scarce resources to primary care, keeping them out of the hands of the rapacious secondary sector. Above all, it must acknowledge the mathematical truth that an all-embracing NHS delivering all wants, as opposed to needs, free at the point of use, is undeliverable in the context of continued low or falling general taxation.

This ballot has eloquently shown that doctors' patience is exhausted. It has shown that ministers must take control of negotiation away from civil servants who subscribe to 'instant fixes' and that they must develop a coherent policy framework if the NHS is to survive. Finally, it has shown that there are only two fixed points in the health firmament: sick citizens requiring skilled clinicians and that the NHS is not an end in itself, only a method of facilitating that primary relationship.

Brian D Keighley
Member, GPC (UK and Scotland) and RCGP Council (UK and Scotland)

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A whole raft of antique skills — percussion, auscultation, even cultivating the deft dance of diagnostic possibilities — will become less important. Doctors will lay fewer hands on fewer bodies...

Paul Hodgkin, Postcards, page 598

I misheard the last word, and in a surprised tone reflected 'an air-conditioned shit?'...

William Hamilton, on deafness in primary care, page 600

contents

WONCA 2001 — Durban

WONCA 2001 was a kind Sydney Olympics for South African general medical practice. Although on a much smaller canvass, this world jamboree also achieved efficiency and ambience. The vibrancy of the rainbow nation was apparent everywhere among the conference organisers, hotel staff and cab drivers, and people on the street. A dip in the warm Durban sea, the enchanting weather, benign rugby fever (the Natal Sharks making the Super 12 Final) and a feeling of engagement with health issues with real teeth were the ingredients of a warm, fuzzy, and slightly heady cocktail. Indeed, the miracle of being in a reasonably operational and sometimes thriving South Africa only ten years after Mandela s release was nothing short of intoxicating.

So much for organisation and image; what of substance? The scientific programme was OK-ish, with inclusivity seeming to take precedence over academic rigour. Most of the best science had already been long published. But fair enough. WONCA s magic has traditionally lain in meeting interesting fellow strugglers from far-flung corners of the globe and sparking together in epiphanies of similarity and comradeship. And WONCA 2001 upped this a notch in a formal sense; with a strong cadre of enthusiastic South Africans chairing sessions and articulating perspectives of a developing nation, First World delegates were implicitly asked questions about their own practices, preoccupations, and subconscious prejudices. Only Third World voices seemed genuinely authentic when struggling to find the words for the impact of AIDS in the rural Third World; violence against women and children in a context of poverty and disintegration; exploitation by tobacco multinationals; and stark ethical dilemmas which literally demand laying one s life on the line (who did not have gooseflesh as Wendy Orr, the doctor who blew the whistle on torture in South African prisons, told her moving personal story with such clear, unstudied freshness?).

Sure, other global issues such as the relationship between environmental damage and changing health threats could have received more airtime, but we did see a developing sense of our international community of family physicians finding formal fellowship in the big issues. At least the inverse care law at an international level had flesh added to the bones; we heard real stories from those parts of countries with the worst health problems having the fewest doctors facing the toughest lifestyle decisions, and supported by the smallest research efforts and clinical budgets. And we clearly saw that, although we work in wildly different settings, we are all interconnected, strange little pieces of the same big puzzle; consider for example Helen Rees s plenary on women s health from a South African perspective and Kirsti Malterud s angle from Norway.

For me, the real challenge for those who attended the Durban WONCA (and were moved in some way while there) is to promote a family medicine approach to international health: like members of any family, countries in the global village affect each other at many levels, and attempting to manage national health issues in isolation will fall short of the mark. In particular, a view of health and economic activity in the developed world as somehow unconnected from events in the developing world is untenable. WONCA s attempts to include, support, and raise the profile of those at the deepest end of the major international health issues of our time deserve our committed support. Without this follow-through, we risk a repetition of past mistakes, a typical example being the exploitation of South Africa as a form of cheap psychotherapy. By not eating Outspan oranges and occasionally standing in the rain outside South Africa House in those dark days of apartheid, many First Worlders felt ennobled. However, now that lines are blurred by complexity, and just when South Africa desperately needs meaty international support to face tough issues common to all developing countries, the hordes of feel-gooders have trooped off to save a different whale.

In Durban, we heard that about one-quarter of antenatal women are HIV-positive. A quick conference in a generic (if less noisy) venue, followed by a game drive and a gin and tonic at sunset before jetting back north, is unworthy of this statistic. To paraphrase Donne yet again, the bells tolling at WONCA 2001 were tolling more clearly than ever before for all of us, and we have been asked to amplify their peal. For starters, this might prevent the forthcoming Orlando WONCA Conference becoming yet another slightly tacky, parochial Yankee yawn, just like the Atlanta Olympics of a few years back!

Christopher C Butler

Research Governance
The Department of Health has recently published its Research Governance Framework for Health and Social Care. (**www.nhsetrent.gov.uk/trentd/resgov/govhome.htm**) Although the Framework relates to England it contains information of value to research active members in all four countries. The standards it sets out will enhance the quality of primary care research and it contains a very useful list of references relating to the good conduct of research.

Steps are now being taken to implement Research Governance in England and the RCGP Research Group has produced some interim guidance for members. The purpose of this is to draw members attention to the important implications of Research Governance; help them decide whether any additional procedures need to be set up; and point out that clarification is still needed on a number of issues relating to primary care research.

Copies of this Interim Guidance have been sent to all College Faculties and it can also be found on the Research Pages of the College web site (**www.rcgp.org.uk**).

Ekkehard von Kuenssberg, CBE, FRCP (Eng), FRCOG, FRCGP

In the setting of present-day general practice, with purpose-built premises, appointments systems, administrative back-up and nursing support, some may find difficulty in visualising the realities of mid-20th century working conditions. While the politics surrounding the NHS remain as turbulent as ever, much has changed. Our College can claim to have been a main instigator of many of these changes, through corporate action and by the pioneering efforts of individuals, prominent among whom was E V Kuenssberg.

A recipient of many honours and awards, Ekke Kuenssberg was one of the principal architects of modern British general practice. Born into an intellectual and aristocratic family in Heidelberg, he grew up under the gathering threat from Nazi Germany. He received his early education at Salem (Kurt Hahn s school before its move to Gordonstoun). As his mother had Jewish ancestry, he came to the UK in 1933 to escape persecution from the Nazis, managing to avoid the attentions of the Gestapo in an exciting journey. Although without funds, he applied to the University of Edinburgh to study Medicine and, after hearing of his predicament, the then Dean, Professor Sidney Smith, recommended to his colleagues his acceptance as a non-fee paying student. This generous gesture was to be justified by Ekke s subsequent career. He graduated in 1939, making Scotland his adopted home. At the outbreak of war, much to his indignation, he was at first interned under the Alien Act but later he served in the RAMC, rising to the rank of Lieutenant Colonel. After the war he returned to general practice in Granton, then a deprived area of the City of Edinburgh. The practice expanded rapidly under his leadership and he inspired important developments in general practice management and research. In particular, he pioneered the concept of the practice team involving close collaboration with nurses, midwives, and practice managers. He was influential in the improvement of general practice records and in the field of research he undertook the first study of cervical smears to be published by a general practice in 1958. Many studies on other topics were to follow and he had the ability to inspire colleagues.

He played a prominent part in local medical politics that later extended to national level; during the first major crisis to hit the NHS in 1963 he (with three other colleagues) was entrusted by the profession to negotiate with the Government of the day. He was able to feed into these negotiations hard-won personal experience complemented by research and other expertise from the fledgling College of General Practitioners of which he was an enthusiastic supporter. The outcome, The Family Doctor Charter , opened the way for general practitioners to improve their professionalism practice from purpose-built premises, work in closer collaboration with nurses, health visitors, and social workers, employ secretarial support, and receive specific training. These and other developments were pioneered in his Edinburgh practice and were to thrust British general practice to the forefront of medical care.

His support for the College of General Practitioners from its inception led to his appointment as Chairman of Council and ultimately to his election as President in 1976. His joy at the granting of the Royal Charter to the College surpassed that occasioned by his own award of a CBE in 1969 (the same year as his mother, then in her 90s, also received national recognition from the German Government for her distinguished service in the community of Heidelberg and beyond).

In collaboration with Sir Derek Dunlop he introduced nationally the Adverse Reaction to Medicines Scheme. He promoted multi-centre general practitioner-based research, most notably the Oral Contraceptive Study and, through the Jeffcote Visiting Professorship Scheme he furthered general practice as an academic discipline.

He travelled widely throughout the world, influencing the development of academic institutes of general practice in many different countries, but particularly in Europe.

In all these activities he was ably supported by his wife, Constance, who herself not only made time for her family of four children but also made her own contribution to academic medicine in Edinburgh. Mourning the loss of a great man, keen though it may be, will be tempered by an abiding sense of the greatness of his achievements and their benefit to patients and profession alike.

Boots the Chemists Research Paper of the Year 2000

Entries for the year 2001 Research Paper of the Year award are currently being invited and the closing date is Friday, 18 January 2002. Entries may be sent to Fenny Green at any time up till the closing date. Information on how to submit an entry may be obtained at **www.rcgp.org.uk/rcgp/research/paperoftheyear/index.asp** or by contacting the Research Office at the College.

Acknowledgements
Thanks are due to the ten panelists who gave their time to judge the entries, to the researchers who agreed that their papers could be submitted to rigorous peer review, and to Fenny Green who, as always, administered the award with great patience and expertise.

In 1996, the College, with generous support from Boots the Chemists, launched the annual Research Paper of the Year award. The award is a high-profile means of recognising, emphasising and celebrating the important role of research in general practice and primary care. In addition, the award draws attention to the large amount of high quality research taking place within primary care, and (it is hoped) encourages more general practitioners to be actively involved in research.

Nominations for the award can be made by anyone and there is no restriction on the subject matter, although the work has to be undertaken in the United Kingdom and must be relevant to general practice. At least one of the authors has to be active in general practice with regular patient contact. Each submission is judged on the basis of originality, applicability, contribution to the standing of general practice or primary care within the academic community as a whole, and presentation. The entries are assessed by a panel of referees representing the wide range of organisations and scientific disciplines involved in primary care research, including academic university departments, the Medical Research Council General Practice Research Framework, the RCGP Patients Liaison Group and the *British Journal of General Practice*.

The panel has a daunting task, and this year was no exception. Twenty-four eligible papers were submitted, with nine short-listed for in-depth discussion. A wide range of methodological approaches were used, including qualitative studies, randomised controlled trials, cross-sectional and cohort studies. The clinical topics covered reflected the diverse nature of primary care: asthma, asymptomatic haemochromatosis, atrial fibrillation, depression, dyspepsia, hypertension, inflammatory bowel syndrome, menorrhagia, and raised lipids. Some papers described methodological developments, such as a new way of measuring deprivation within a practice, or evaluations of new service developments, for example the role of nurse practitioners in managing minor illness. Most papers were published in the *British Journal of General Practice* (nine papers) or *British Medical Journal* (eight papers), although another seven journals were involved.

This year s winner was the impact of patients preferences on the treatment of atrial fibrillation: observational study of patient-based decision analysis by Protheroe et al.[1] This paper described the use of decision analysis to understand better patient preferences for anticoagulation treatment. Among 97 elderly individuals with atrial fibrillation, decision analysis indicated that only 59 (61%) would prefer anticoagulation treatment, considerably fewer than the proportion that would be recommended treatment according to guidelines. Of 38 patients whose decision analysis indicated a preference for anticoagulation, 17 (45%) were already on warfarin. Conversely, 28 (47%) of 59 patients were not receiving warfarin although the results of their decision analysis suggested that they wanted to be.

The panel recognised that the methodology would not be directly applicable to today s practice. Nevertheless, the panel felt the paper was an excellent demonstration of the potential role of decision analysis in patient-centred health care. The paper also highlighted an important guidelines limitation, notably the difficulty of translating average effects from randomised clinical trials to specific estimates of risk for particular individuals. This paper was an exciting addition to the debate around the value of guidelines and demonstrated that primary care researchers are both willing and able to tackle complex research issues.

Another paper, randomised controlled trial on non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical Effectiveness by Ward *et al*,[2] was highly recommended by the judges. This collaborative study in London and Manchester compared usual general practitioner care with two psychological interventions in patients with depression. All groups improved over time. At four months, both psychological intervention groups showed larger improvements in their Beck Depression Inventory scores than the usual general practitioner care group. By twelve months, however, there were no significant differences between groups. The panel thought that this was a very timely study given recent expansions in general practice-based counselling and the currently limited evidence-base for its effectiveness. The study also emphasised the need to look at change over relatively long periods of follow-up; very different conclusions would have been reached had the study stopped at four rather than twelve months.

Decisions made in primary care often have far-reaching consequences for patients, their families and friends, primary and secondary care. It is important, therefore, that clinical, managerial and policy decisions are based on robust evidence derived from high quality research. Few would argue with the statement that the evidence base for primary care needs to be strengthened, and that primary care research capacity needs to expand substantially if the evidence-base is to be achieved. It would be wrong, however, to forget that many examples of excellent primary care research already exist. All of the papers given the accolade of RCGP/Boots the Chemists Research Paper of the Year fall into this category, powerful exemplars of the potential of primary care research.

Phil Hanniford

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Journal Watch

The *BJGP* and its standards

MEETING in April, the Editorial Board looked at the performance record for submissions, reviews, and publication for the past year. In 2000 we received 614 submissions. This is fewer than the number for 1998 and 1999, which may own something to the timetable for the Research Assessment exercise that all the UK universities are subject to (to count in the census, all papers had to be published by December 2000). The largest proportion (38%) came from academic departments of general practice, with the next largest (15%) from service practice. By far the largest proportion come from the UK (82%), with the next largest number being submitted from the Netherlands (7%) and the Scandinavian countries (3%).

There was much discussion about the delays to publication. Authors find this particularly frustrating, and some of the readers will have spotted that there is sometimes a surprisingly long delay between initial submission and publication. The aim is to reply to everyone within three months of submission. Last year we only achieved this for 63% of submissions (replying to 90% within 4 months). The Board accepted the views of the staff and the general plans, particularly moving towards on-line submissions, to tightening the system up. The one concrete recommendation made was that we should identify and reject more papers before sending them out for review, on the grounds that we shouldn t get referees to review papers when there is little or no chance of publication, and that for authors a quick rejection is more helpful than a slow one. This does represent a change in policy, and we hope that authors will welcome it.

One other piece of data may be useful to authors. In the course of the past year, 17 authors appealed against the editor s judgement. At the time of the meeting, two were still awaiting final decision. The original decision was confirmed in 10 and overturned in five. In other words, if you think that the editor or referees have made a mistake there is a 1 in 3 chance that you will win your case, but remember that the appeal process itself takes another two to three months.

David Jewell

declan fox

Greetings from O'Leary

IN the morning I admitted an old dear with LVF and atrial fibrillation; she was on digoxin and Frusemide and Lisinopril, but had gone down despite that. I ordered cardiac enzymes, creatinine, electrolytes, and ECG; all done by the time I finished my coffee break and hand-delivered to me at the desk in Emergency. The coffee is often hand-delivered too.

In the evening I took a three-inch wood splinter out of a wee girl s thigh. It had gone way up subcutaneously; I had to enlarge the entry wound to get at it and when I had it out I realised that it had broken inside and there was another piece higher up. I removed that through another incision. Time, patience, EMLA, some Lignocaine, wonderful motherly nurses all helped her stay pretty calm.

In between I saw maybe 40 patients in my office; a lot of regular GP stuff and a few more serious. And during the night I got up to see someone with chest pain which turned out to be an atypical pneumonia there s a lot of it around out here.

O Leary, Prince Edward Island, has a population of 800. Four GPs and a 30-bed hospital (17 long-term care, 13 acute) serve several thousand; without GP lists of patients I can t be sure exactly how many, but at least 15 000 usually come to us first.

I have fun out here; I am challenged, I learn, I am stimulated. I do a lot of things I used to do in hospitals and others I never did, such as thrombolysis and plaster casting.

What don t I do? I'll tell you what I don t do.

I don t spend more than 90 seconds a day on claiming fees, even though the fees/allowances system is vastly more complicated than in the NHS. I don t spend more than five minutes per week writing sick notes. I don t spend any time at all on health board managerial rulings; I have no terms and conditions of service to follow; I am an independent contractor and my only contact with the health service system is when my secretary sends my billing down the line on alternate Thursdays. They pay three working days later, just in case you want to know.

And I spend zero time worrying about complaints. They are pretty rare here.

The perfect place to work? I don t know. But it beats the hell out of most places I have been and I find it very easy to stay sane, motivated and satisfied with my work out here.

futurology

This is the fifth article in our continuing series, Postcards from the 21st Century, commissioned and edited by Alec Logan, Deputy Editor, BJGP*, London, and Paul Hodgkin, Primary Care Futures.*

Postcards from the 21st Century

Dramatic changes

DAVID always found it difficult to break bad news, and confirming Kate s worst fears about the funny tingly feelings she had been having in her legs was never going to be easy. He tried to tell her about all the help available, and gave her the contact number for the local MS support group, but he still felt terrible. And then, while David was reviewing the video of his consultation, Kate began to explain to him how it felt to her: I don t want to be told about how good you ll all be at looking after me. I don t want any of this it feels like shit, and I want someone to be here with me . David stopped trying to offer reassurance it had, he realised, been mostly for his own benefit anyway and acknowledged to Kate that he recognised how bad she must be feeling. Paradoxically, they both began to feel better.

This consultation was part of a Breaking Bad News workshop where actress Sue Power was playing Kate, and was able to give specific feedback not only during the consultation but also the debriefing afterwards. David was offered the opportunity to replay the moments of high danger within the safety zone of simulation. He was also able to use Kate s ability to reflect on her own experience as a crucial point of reference It gave me the only instant and honest feedback from a patient that I have ever experienced ... it enabled me to change something I had done for over 15 years. Thank you .

Actors, video, and simulated patients have of course been used to improve communication skills for years. However, much of the potential may be lost if the actors do not stay in role and are not included after the consultation. Sue Power is a member of Spanner Workshops, a group of actors who ensure the patient s experience remains central by giving continued feedback throughout the doctor s self-appraisal of his or her performance. Spanner members develop the characters of the patients they play and group members often lead the workshops. This is not merely a checklist approach to communication skills although specific skills are indeed quickly acquired and could be ticked off. Drama uniquely has the potential to find and explore chinks in a reality that is so familiar that it seems sealed: David undid and rebuilt his own consultation, using the patient s experience as a central touchstone.

He was also able to do so because he felt safe. His learning was not a process where he felt as if he were stumbling towards insights already visible to the teacher. Rather, he was on a voyage of discovery. Theatre techniques can allow for risk-free exploration: the minutiae of human interactions and the unpredictability of the moment can be reproduced and tinkered with. The structured feedback enabled David to identify and build on his own strengths, so that he ended up realising there are some things I do well! . David was not acting: It felt, he said, incredibly real . From this basis it was possible for him to hear what Kate had to say about how painful her situation felt, and to offer her some deeply appreciated support.

Progress Theatre uses these principles in a slightly different way: This theatre company is constituted specifically to illuminate the social processes within midwifery. I Don t Know How She Got Pregnant is a series of high impact scenes illuminating the uncomfortable and often invisible issue of the maternity care of survivors of sexual abuse. The material for this piece was gathered by talking to survivors of abuse and to midwives, and it is performed by Progress actors, most of whom are also midwives themselves. The scenes are presented to the audiences of midwives and other staff, who recognise themselves at work. They are then asked: Does it have to be like this? Played for a second time, the audience can stop the action and change what the protagonist the midwife does. The actors consult with the audience and draw on their own experiences to create new ways of dealing with the situation. New behaviours are incorporated but, more importantly, questions are asked about existing practice and why it is as it is. There may be no consensus about how to improve things, and there are no magic wands: the audience can change nothing but the behaviour of the midwife within realistic parameters. The theatre is there to provide a forum; for debate, for reflection, for tinkering in short, for self-determined learning. What the audience are watching are their own interactions with colleagues and patients, their own professional language and values,

Further Reading

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Baker K. Acting the part: using drama to empower student midwives. *Practising Midwife* 2000; **3:** 1.

Morris P, Burton K, Reiss M, Burton J. An action learning project about mental health issues in the consultation. *Education for General Practice* 2001; **12:** 19-26.

Thistlethwaite J. Learning Curve. *Update*, 22 March 2001.

Reports on the work of Progress Theatre are available from Jane Durell. E-mail: **J.Durell@sheffield.ac.uk**

the familiar taken-for-granted assumptions of their own world. Some of the less visible aspects of midwifery culture are brought up for discussion and review. They see their world as it is, but they also see it as capable of transformation. They can begin to explore the dissonance between how it is and how it could be, in this case either by entering the scene themselves or by directing the actors.

At each performance a kind of symbiosis emerges between the actors, the material, and the audience. As the debate and scenario evolve, it is no longer clear who is performing what to whom. Once again, this ownership of the process by the learners is a key principle. If improvements are taught rather than learnt, they easily become a stick. If learners are in charge, exploring the gap between reality and aspiration loses its threat: I felt as if the idealist in me had been fed , said one participant, but I was also more aware of what it is that makes us fall short of this . For this is situated learning, and the context of practice as well as the behaviours of individual practitioners can be opened up for scrutiny and debate. The irascible colleague, the late running clinic, the excessive demands of the workload not to mention the back-watching, litigation-conscious backdrop to our relationships these are all flagged up and made visible by midwife participants at a Progress event.

Using theatre allows for analysis of one s own behaviour and culture, and for rehearsal and relearning within difficult situations. Travelling between what is and what could be mobilises values, context, and experience in the service of learning. Workshops cease to be about checklists, wish lists or speculation and begin to be about living and experiencing new ways of improving patient care. David described his experience of this dramatic way of learning: It was both realistic and safe, which is how I d want the consulting room to be for any of my patients, particularly those facing difficult diagnoses . And Kate? Every time I play her or anyone else I learn something new, says Sue, and it can sometimes be incredibly painful. But facing that is invariably helpful for the patient, and I reckon for the doctor too .

Kirsten Baker

What happens when we can see everything?

In the USA anyone can buy themselves a CT scan. A whole body scan will cost you around $850, partial scans proportionately less. For this you get the scan, the report and a consultation with the radiologist. Most facilities are currently long over-booked. If technological advance and swelling volumes work their usual magic, it is a fair bet to assume that, within 10 years, the cost of a whole body CT scan will have dropped by at least one order of magnitude. Walk-in MRI scans will no doubt follow soon after.

Such advances will change more than how we diagnose cancer. A whole raft of antique skills — percussion, auscultation, even cultivating the deft dance of diagnostic possibilities — will become less important. Doctors will lay fewer hands on fewer bodies. And disease will become more concrete, easier to grasp: ‘see that shape right there, that’s where my problem is’.

Widespread access to whole-body scans will bring its own problems of course. We may spend as much time disentangling people from the web of anxieties spun by false positives as on diagnosis itself. Still, repeat scans will no doubt do much to alleviate these fears.

Doubts about our own utility may be harder to allay. If the arcane arts of diagnosis become as mundane as the 24-hour pharmacist at Tesco then what exactly is so special about doctors? And what price gatekeepers if the cost of investigations on the other side of the gate has become trivial in comparison with the comfort they afford the public?

Just as seeing our world from space — an icon of serene and fragile beauty — transformed our view of the external environment, so 3D colour images of the foibles of one’s own beating heart, picked up with the small change at the supermarket checkout, will alter our relationship to our bodies. And as genomics unpacks the deck of cards within our cells we will see the jokers within, beckoning and mocking.

Genomics and imaging render our bodies both more visible and more problematic. The land beneath our skin becomes a place of exploration and ultimately choice. The body becomes a canvas for art. The epidemic of tattooing and piercing, the bizarre intra-gastric ‘performances’ of artists such as Stelarc and the dissected bodies currently on exhibit in a Berlin gallery — all explore the newly revealed spaces of the body. Twenty thousand years ago the cave painters of Lescaux left imprints of their own hands alongside the bisons and mammoths. Today’s images continue the fascination with the body. Seeing the inner landscape our sense of corporeal unity begins to break and the indivisible ‘I’ within my skin becomes ‘other’.

Glueck MA, Cihak RJ. Everything you wanted to know about your anatomy but were too afraid to ask. *BMJ* 2001; **322:** 873.
For more information on walk-in CT scans see **www.Lifescore.com** or **www.insdietrac.net**. For body-as-art see **www.stellarc.va.com.au**. For information about the Berlin exhibition of dissected bodies see **www.koerperwelten.com**

hodgkin@primarycarefutures.org

The Docker's Daft Pension Rocket ship*

When the editor of the BJGP received a brief report that we had submitted on the subject of deafness facilities in primary care, he confessed he was disappointed with the piece.

This is nothing new for us from a journal editor of course. This time he meant that the report was sterile, displaying none of the human issues of the struggle deaf patients have with their doctor.

Thus, we four have accepted the challenge to show how deafness can distort the use of general practice. These mini-essays are entirely anecdotal, un-evidence-based and have zero statistical significance; this should please at least 50% of practising GPs.

The patient's view

DILEMMAS, doctors, and deafness. The three Ds, just like the three Rs for education. What are the dilemmas, and how can doctors help?

We have been profoundly deaf since birth, fitted with hearing aids to compete in this world. Our preferred language is sign language, with spoken second, augmented by lipreading and using our grey matter to improvise intelligent guesswork for the rest. So what are the problems?

Despite the technological advances, such as cochlear implants, digital hearing aids, and environmental visual equipment which have changed many peoples lives problems persist. These aids do not restore you to normal. As a deaf human being, with one of five senses impaired, we are still left feeling frustrated, with relationships that are short-fused, time-consuming, impatient, and at times feeling quite alienated. Why?

Consider this. So many social interactions such as requiring advice, help, or simply needing to talk requires the telephone. Just pick up the phone is the catchphrase. For a deaf couple like us, it s not that easy, although there is a service for the hearing-impaired, called Typetalk. Let s ask for a GP appointment and remember we feel ill, and perhaps emotionally highly strung. We first ring Typetalk using a textphone with a keyboard, typing in our account details, phone number and the details of the person to call. The receptionist answers, and we start a three-way conversation, with us typing our symptoms try typing what sort of pain you have! for Typetalk to voice to the receptionist. All this can easily take 20 minutes, or at worst three-quarters of an hour, through no fault of Typetalk who are doing a wonderful service. Too much trouble? Try walking or driving to the surgery instead (ignoring the issue of distance). We then have to endure the procedure of making sure we are understood. The Do you live in the dark ages? Haven t you heard of the telephone? look comes our way. Are we simple, or are we deaf? Even then they talk loudly at us: Sorry, the doctor is fully booked today do pop back for any cancellation, or ring back later!

Worse, imagine the out-of-hours problem. Try using a textphone to an answering service; it s unbelievable. On occasions, we have had to textphone relations in Devon to ask them to phone on our behalf, or go to A&E for something that could, and should, be dealt with by our family doctor.

At the surgery, the receptionists generally look downwards when asking our names. We then say, Excuse me; I am deaf, and need to see your face to lipread. The usual response is for them to look up to talk, but turn away again while talking. It is a constant pain having to repeatedly remind them when they should remember to look at you. In the waiting room we cannot hear the tannoy calling us for the appointment; the receptionists don t come to notify us either. We have been left waiting for ages, which is no help if you ve taken an hour off work.

To be fair, our doctor is a good man, patient and happy enough to repeat his advice in simple layman s terms. However, we still have to remind him to face us and remove any obstructing object from his face so that we can lipread. Also, he talks to the computer when asking our problem. He has been our doctor for fifteen years you would think he would know to look at us by now!

We are lucky really. Many of our deaf friends, who do not have intelligible speech, have to make additional arrangements to organise for a British Sign Language interpreter to be available. Delay is inevitable, with the hassle adding a headache to the medical problem. For our deaf community club, we approached the manager of our health centre requesting a direct line for textphone users. It would be more effective, personal, and less time consuming, and certainly not discriminatory. Too complicated and costly was the response. That was five years ago, in the 20th century!

Our best advice is don t get sick; stay deaf, it s easier.

David and Joanne Rose

A hearing GP's perspective

As a full time GP I have a considerable number of patients on my personal list who have reduced hearing, plus five who are profoundly deaf. For most of these patients, hearing aids and our surgery loop allow adequate communication. For some, their hearing problems are insurmountable barriers to good doctor patient communication.

The whining hearing aid is a recurring problem with a small number of patients. The high-pitched whine of hearing aid feedback takes me back to those student rock concert days, but then that heartsink feeling tells me that the next five minutes will be spent adjusting the volume, or worse. On one occasion the hearing aid fell apart in my hands and my attempts at a DIY repair only made matters worse. I handed back the bits and arranged an urgent outpatient appointment at the audiology department.

Some patients never get the hang of their hearing aid; one patient always comes to surgery without his hearing aid in his ear. He then takes it out of his pocket and inserts it into his ear in the consultation along with debris from his pocket. Not surprisingly, the hearing aid seldom worked and we often had to remove it because it was worsening his deafness by plugging his ear or because it was whining. After 35 new hearing aids the audiology department gave up. His dog had eaten three.

essay

The hearing aid is a blessing for some and a curse for others. Patients presenting for hearing aids are often sent by a spouse or family member, often presented as My missus sent me down because she thinks that I am deaf but it s only her saying I can t hear. I usually find that these patients really are deaf but don t want to admit it and don t want to use a hearing aid.

Of those who are profoundly deaf and get no benefit from hearing aids, most lipread very well. Most lipread so well that I can forget that they are deaf and need to be reminded to slow down and maintain good eye contact (no typing on the computer, writing a prescription or reading the notes while taking a history). One patient cannot lipread me easily, though he lipreads his family well, so the consultation is spent writing down most of what I have said. This ensures that the information has been accurately received. My writing is then taken home to family who are then aware of what has taken place.

Unfortunately our NHS does not provide our deaf patients with the best equipment available. If a patient s deafness is restricted to certain frequencies then a hearing aid can be provided that will magnify only those frequencies. These hearing aids are much more acceptable to patients but are not widely available on the NHS probably because they are expensive. With such a common problem, could the NHS not offer a better service?

Dave Russell

The deaf GP's view

I am a patient too, of course. I will usually make appointments in person simply because it s easier. The other upside is the written card stating my appointment time and date. I ve missed appointments made solely on the phone by getting the date or time wrong. Typetalk only partly solves the phone issue. The other problem with Typetalk is that it takes quite a time to set up each call so you don t bother telephoning to check the arrangements. It s also pointless trying to telephone me if there has been an alteration in plans; I don t hear it ring. It may become easier later this year when each Typetalk user will have a code to key into the phone that should automatically get the system operative. Although the telephone number will end up being so long you will think you re phoning Saturn, it will mean Typetalk is used more. So, receptionists, expect more of us on the line. As an aside, Typetalk can be very handy if you have a sticky phone call to make; people are generally extra helpful in dealing with a disadvantaged customer. I once let someone down badly, and he blew his top. The typist relayed his exact words (they always do), but added in brackets, He sounds rather angry . I fully expected ??*?!! or expletive deleted , but he soon realised it was little point railing at an interpreter and so calmed down. We sorted the problem much quicker than if I d heard his views on my parentage directly.

Embarrassment is another key issue. It s socially acceptable to request a repetition of a misheard sentence, and just about allowed to have a second repeat. After the third request both parties are embarrassed and it is easier to pretend the item has been heard. Even my wife, let alone my GP, can t tell at times if my OK, message received is real or a cover-up. The solution of asking the speaker to rephrase rather than repeat is actually quite a difficult concept to get over. The idea is that some sounds are easier to hear than others (I can hear small , but not low ; I sometimes hear little). In English there are synonyms for almost everything, so it should be easy to reword a missed sentence. A GP could change I don t think we need to use antibiotics; it should get better itself which the deaf patient fails to pick up into We can avoid tablets to kill the germs; your illness will go away without them . Same meaning, different words.

It is also perfectly acceptable to write things down. I have a handful of deaf patients where the consultation is entirely written. Oddly, it s quite difficult to use colloquial language when writing. It s surprisingly easy to write antibacterials not indicated; spontaneous resolution expected. The other plus is that the patient can take the note away to show to their loved ones (and chortle at your spelling).

Eye contact is extremely useful for lipreading (don t ask me why, but sunglasses completely ruin my communication). This means that we GPs must be much more careful when using the computer in the consultation with a deaf patient. The small time-saving of keying in the prescription during the consultation is probably outweighed by extra repetitions I mean rephrasals generated. For me it s easy; I have to lipread, so must concentrate solely on the patient. This undivided attention gives the impression that I m doting on every word, thus making me undeservedly popular. In reality, I m desperately trying to follow. Still, it means I summarise the history at the midway point of the consultation to ensure I ve got the salient points. This should please all the GP textbook writers.

I still make mistakes, but they can sometimes be a powerful tool. A prim elderly lady was describing how her holiday cruise was ruined by diarrhoea, despite it being a lovely air-conditioned ship. I misheard the last word, and in a surprised tone reflected an air-conditioned shit? Brief pause and then rolls of laughter. It transpired she had been faecally incontinent and this was what had ruined the cruise, but had been too embarrassed to say so. I only wish she wouldn t call me her air-conditioned shit every time she sees me now.

William Hamilton

*The doctor deaf patient relationship

Resources

Typetalk The site gives very good details of how the service works, and allows practices to open an account, should they wish.
http://www.rnid-typetalk.org.uk/

RNID Typetalk, PO Box 284, Liverpool L69 3UZ.
e-mail: helpline@rnid-typetalk.org.uk
0151 709 9494

Equipment
http://www.rnid.org.uk/html/shop_home.htm
This site is excellent for all the equipment, with a 10% discount for RNID members. Deaf people don't pay VAT so it's a further 17.5% off. Whether a practice could get the VAT off is debatable!

RNID
This is the main RNID page. Both it and Typetalk allow downloading of information leaflets about all aspects of deafness and communication. If GPs want to only hit one site, this is it.
http://www.rnid.org.uk/index.htm

RNID Information Line
The RNID Information Line offers free confidential and impartial information on a range of subjects, including employment, equipment, legislation, benefits, and many issues relating to deafness and hearing loss. There are trained Information Officers who respond to the requests that come in via telephone (both voice and textphone), e-mail, letters, and fax. although they do occasionally see people face to face.

The remit of the service is to enable as many enquirers as possible to take further action themselves. If this is not feasible or there may be a better course of action, the Information Officers give details of relevant local and national organisations that may be able to help in a different way.

Telephone: 0808 808 0123 (freephone)
Textphone: 0808 808 9000 (freephone)
Fax: 020 7296 8199
E-mail: **informationline@rnid.org.uk** or write to:19-23 Featherstone Street, London EC1Y 8SL

digest

Medical Humanities
Edited by Martyn Evans and Ilora Finlay
BMJ Group, 2001, PB, 321 pp, £25.00, 0 72791610 6
Medical Humanities: a practical introduction
Edited by Deborah Kirklin, Ruth Richardson
RCP, London 2001, PB, 158pp, £22.00, 1 86016147 2
Medical Humanities
(Edition of the *Journal of Medical Ethics*, DEC and JUN), BMJ Publications

In a letter to a medical student, William Carlos Williams (1883 1963), one of the great 20th century American poets and doctors working among the poor in northern New Jersey, wrote:

> *'Look, you're not out on a four-year picnic at that medical school, so stop talking like a disappointed lover. You signed up for a spell of training and they're dishing it out to you, and all you can do is take everything they've got…'*

This outlook is no longer prevalent in most medical training. There is general consensus that students should be taught to express emotion and empathy, and to feel that the process of training is rewarding. It is believed that art and literature can sometimes staunch burnout among doctors. An underlying assumption of those involved in the medical humanities is that the study of just about anything other is restorative.

Aiming at such restoration, contributors to the textbook *Medical Humanities*, *The Medical Humanities Journal*, and the *Practical Introduction* bring insight from various backgrounds, including philosophy, history, literature, art, anthropology, sociology, theology, as well as medicine. This approach, as Jane Macnaughton (among others) points out in an article, Why Medical Humanities Now? is not merely additive but integrative, in the sense that it sees medicine and the humanities as one:

Whereas the additive view sees the humanities as another course added on to what the students already do and as having a broadly educative value, the integrative view sees humanities as an integral and essential part of the course (*Medical Humanities*, page 199). Or, as Robin Downie puts it: Literature shows us that in order to understand any particular action or character it is necessary to see the interrelatedness of them all (ibid., page 208). It is true, as Deborah Kirklin points out in the *Practical Introduction*, that an education broadened by the humanities, is no guarantee that a better doctor will be produced . Yet, there seems to be agreement that medicine should be regarded not as a science alone but also as a natural part of the humanities.

Of the three works, *Medical Humanities* is the most comprehensive and useful, though the other two have much to commend them. It is divided into four parts, with an introduction to each section. The third part, Changing Attitudes , concentrates on practical issues in the application and evaluation of medical humanities in training: why teach humanities; how to convince the Dean to introduce medical humanities into the programme; how is the medical trainee to be graded? This work in progress reflected evolving views on the nature of health.

The readership of *Medical Humanities* and the *Practical Introduction* is fairly specific, aimed chiefly at those involved in teaching and developing programmes in the humanities for health care workers. The *MHJ* has broader and vaguer ambitions. Perhaps in consequence it has the feel of a fledgling project. It is not clear whom it wishes to reach, apart from those in health care for whom art and literature matter. In some respects, the three publications overlap. The same writers sometimes appear (Gillie Bolton has written for all three); sometimes even the same articles are reworked.

Ruth Richardson, a professional interdisciplinary historian, has contributed fundamentally the same work, A Necessary Inhumanity , for the *Practical Introduction* and the *MHJ*. She links the shocking revelation that 19th century doctors dispensing medicines in English work houses had to pay for medicines from their own salaries, and were prone to corruption, to the current topic of general practice budgets and rationing, and draws a parallel between the taking of specimens without consent in the 1780s and the recent outcry in Alder Hey. The title of her article aptly alludes to William Hunter s urging his students to gain a necessary inhumanity through dissection. She prefers this phrase as being more honest and desirable than clinical detachment ; and this leads to the perpetual question of whether the student pays too high a price for medical knowledge. This theme is echoed in *MHJ* June 2001 in What Price Dissection? by Francis and Lewis, of the University of Wales modular scheme of Medical Humanities, and the article itself is an attractive advertisement for their medical school programme.

Deborah Kirklin, in the Practical Introduction, has a section on Creating space to reflect and connect : the *MHJ* also provides space for doing so. Iain Bamforth s Kafka s Uncle illumines Kafka s story *A Country Doctor*, and Peter Byrne s The Butler(s) DID It , on Dissociative Identity Disorder in cinema, are good examples of the intertwining of art and medicine. Sections of the journal, such as Gillie Bolton s Opening the Word Hoard (selections from creative writing), along with the discussion of narrative as therapy, could run and run. Not surprisingly, in view of the complex

interdisciplinary nature of the subject, some of the articles in the June 2001 issue noted could be edited more stringently. A number of these, crammed with references, are too abstruse for the general reader. However others, such as Richard Meakins editorial for the education and debate section, are succinct and sensible.

The view that art and medicine should be integrated and that health workers can gain from an appreciation of the arts is not new, though each of the works under review offers new illuminating perspectives with potentially radical practical implications.

William Carlos Williams (an underused resource) wrote a collection of stories, *The Doctor Stories* and an autobiography, that anticipate narrative-based medicine . His autobiography expresses the main aims of *Medical Humanities*, the *Practical Introduction*, the *MHJ* and other publications along these lines:

> *'The Physician enjoys a wonderful opportunity actually to witness the words being born. Their actual colours and shapes are laid before him carrying their tiny burdens which he is privileged to take into his care with their unspoiled newness. He may see the difficulty with which they have been born and what they are destined to do. No one else is present but the speaker and ourselves ... Nothing is more moving'.*

Miriam Skelker

Occupational Health Matters in General Practice
Ruth Chambers, Andy Slovak, Gordon Parker, Stephen Moore, Donald Irvine
Radcliffe Medical Press, 2000, PB, 208 pp, £18.95, 1857754638

Hunter's Diseases of Occupation. Ninth edition
Edited by Peter Baxter, Peter H Adams, Tar-Ching Aw, Anne Cockroft and J Malcolm Harrington
Arnold, 1999, HB, 1000pp, £155, 0 34067750 3

EVERY so often a new book lands on a reviewer s desk which can be recognised immediately as a must-have for a readership. *Occupational Health Matters in General Practice* comes into this category for general practitioners. This is not to say that there is not room for improvement in a second edition, because there is. The authors do not discuss the background to the emergence of occupational health as the discipline that is supplanting both occupational medicine and health and safety in the eyes of many professionals. Nor do they warn readers that, in the field of occupational health, they may find themselves dealing with practitioners who have done day release doctorates and refer to themselves as doctors , even though they have no medical qualifications. The book does not make a clear distinction between the legal liability of the controlling mind in any general practice to comply with health and safety law and the responsibility practice managers to observe, on the basis of specific training received, those health and safety duties that have been allotted to them. Further, the book has eight cartoons that are irritating and do not enhance the text. On the other hand, the book contains a wealth of practical information and exercises, presented in format that is easy to assimilate. It will enable many general practitioners to add a new and important dimension to their work.

The NHS Plan, published by the Government in 2000, referred to the provision of £8 million for general practices to develop occupational health services. This provision will enable general practices, not only to provide occupational health care for their staff but also to enable them to care more effectively for their working patients. The controlling minds of general practices have had legal liability to provide such care for their staff since the introduction of the Health & Safety at Work Act in 1974. Yet the paper by Kennedy *et al* shows that, in 82 general practices in one London Health Authority, there was a lack of knowledge and a failure to implement health and safety legislation that the authors describe as serious . Clearly, this situation cannot be allowed to continue. NHS Trusts have been prosecuted and there is no reason to suppose that general practitioners as employers and Primary Care Groups and Trusts will continue to enjoy immunity once financial resources have been provided.

Hunter's Diseases of Occupations is to occupational medicine what *Gray's Anatomy* is to anatomy. Since Donald Hunter s text was first published in 1955 it has quickly established itself as an indispensable work of reference for those working in the field of occupational medicine. All general practitioners should have access to it. With 11 chapters and 64 contributors the ninth edition has 25% more text than the eighth edition, as new chapters on mental health, shift work, imaging in occupational lung disease, chronic airflow obstruction, welding and diseases of the kidneys, liver, nervous system, and blood have been added. As previously, the chapters are succinct, well referenced reviews of all aspects of occupational medicine. Especially useful chapters are those on repeated movement and trauma (Palmer and Cooper), occupational asthma (Newman Taylor) and occupational diseases of the skin (Rycroft). However, the allocation of a mere three pages to stress at work in a book of 1000 pages will come as a disappointment to those looking to expand their knowledge of this topic.

Victor Bloom

tudor hart s books

OSLER S goal was *aequanimitas* peace of mind. For physicians to attain this in 1904, surrounded by misery and premature death they could understand but not change, required mystical states that ten tomes of heavyweight self-improvement might induce.

Students today face the opposite dilemma. Our useful and effective knowledge exceeds the capacity of our society to apply it to all in need. What can be done, usefully and effectively, expands faster than what is done, especially for people and places in greatest need. Real peace of mind today depends on doing our best to apply our knowledge fully to all who can benefit, refusing to accept wallets or Gold Cards as relevant to our decisions. This demands imagination, courage, and above all staying power to defy conventional cowardice.

I think my ten books provide a tougher, more human, and more contemporary world view. True peace of mind is a reward of struggle, not contemplation.

1. Jacob Bronowski. ***The Ascent of Man***. London: British Broadcasting Corporation, 1973.
2. William H McNeill. ***Plagues and Peoples***. Oxford: Blackwell, 1977 (USA 1976).
3. Friedrich Engels. ***The Origin of the Family, Private Property and the State***. London: Lawrence & Wishart, 1940 (first English translation).
4. Bertolt Brecht (trans. John Willet). ***Life of Galileo***. London: Eyre Methuen, 1965. This edition includes Brecht s important preface to the play.
5. John Coope. ***Doctor Chekhov: a study in literature and medicine***. Chale, Isle of Wight: Cross Publishing, 1997.
6. Joseph Heller. ***Catch 22***. New York: Random House, 1955.
7. Ken Kesey. ***One Flew Over the Cuckoo's Nest***. New York: Methuen, 1962.
8. John Irving. ***The Cider House Rules***. London: Jonathan Cape, 1985.
9. Pat Barker. ***Liza's England***. London: Virago, 1996. First published as *The Century's Daughter*, by Virago in 1986.

Finally, for the social history of UK medical practice over the past century:

10. Julian Tudor Hart. ***A New Kind of Doctor***. London: Merlin Press, 1988.

If I hadn t the cheek to put my own book in my Top Ten, I wouldn t have written it. But I would say that, wouldn t I?

Julian Tudor Hart

Unacknowledged Legislation: writers in the public sphere
Christopher Hitchens
Verso, 2000
HB, 358pp, £17.00, 1 85984786 2

THIS was my first brush with collected literary criticism. I wondered what its purpose might be. Hitchens foreword gives some hints, and elucidates his title. It is from Shelley:

> *'Poets are the hierophants of an unapprehended inspiration; the mirrors of the gigantic shadows which futurity casts upon the present … Poets are the unacknowledged legislators of the world.'*

Legislation is prescriptive. Writers, he is saying, powerfully shape the future. He quotes Auden on the suppression of the Prague spring by Warsaw Pact tanks:

> *The Ogre does what Ogres can,*
> *Deeds quite impossible for man,*
> *But one prize is beyond his reach,*
> *The Ogre cannot master Speech.*
> *About a subjugated plain,*
> *Among its desperate and slain,*
> *The Ogre stalks with hand on hips*
> *While drivel gushes from his lips.*

'The Milkmaid', by Jan Vermeer, from the Vermeer and the Delft School *exhibition at the National Gallery, London, from 20 June to 16 September 2001.*
Photo: © Rijksmuseum, Amsterdam.

In due course, Hitchens says, the Ogre was brought down by playwrights and poets, men of words.

Wilfred Owen, Hitchens says, utterly turned over all the furniture of my mind, inverting every conception of order and patriotism and tradition on which I had been brought up :

> *'Certainly flowers have the easiest time on earth. "I shall be one with nature, herb and stone", Shelley would tell me. Shelley would be stunned: The dullest Tommy hugs that fancy now. "Pushing up daisies" is their creed, you know.'*

Criticism, presumably, should be a part of this turning over of minds and Ogres. The essays which make up the meat of the book are reviews of a little more than a century of Anglo-American writers encountering politics or public life, all written by Hitchens in the last decade. Their language varies according to its original audience. For *Vanity Fair* he is as succinct as Auden. For more learned periodicals his prose is Shelley-ish, and for me it gets in the way. Of Powell s Dance he says:

> *'The events and developments are so widely spaced in time, yet so intimately filiated by the social class and background of the participants, as to make any complaint about the over-strenuous exertions of coincidence seem almost ill-natured.'*

A bit of a pose? Powell makes ample space for his coincidences would have done the job.

Hitchens refers to constellations of literary and historical figures and events. The breadth of allusion is breathtaking. But, even among familiar characters like Orwell, the discussion becomes for me, too extended, arcane, and bewildering. Rather than being lead to new and fascinating territory, I was slightly too often plunged into impenetrable cultural jungle for which, to my shame, I had no map.

Hitchens is at his very best in the company of his hero Oscar:

> *'Socialism's great benefit would be the abolition of that sordid necessity of living for others.* (Wilde)

> *'The effect of this rather flippant seeming introduction was to peel the whiskers from the face of church and state which had bound every citizen into a nexus of obligation and guilt.* (Hitchens)

He offers compelling reminders of the

commitment to socialism of men like Orwell who fought in Spain, was shot through the neck by a fascist bullet, but was as much in danger from Stalin s NKVD as from Franco. He is cosily well disposed to Michael Frayn, and fiercely and justly protective of Salman Rushdie. He exposes Kipling s jingoism without reserve, and yet deals sensitively with Kipling s loss in battle of his only son. He admires Conan Doyle, but can still be politely withering about the spiritualism which overtook him in old age. On Ireland he is internationalist and pragmatic. War and racism are recurring themes.

This book may well be full of wonders for a serious student of writing and public affairs. For the rest of us, I suspect, criticism comes best in small helpings, and best of all, firmly connected to some recent and stimulating reading which we want to explore fully. Still, I have been stirred to dust off an old Sherlock Holmes, I am curious about Rosa Luxembugh and Jean Jaures, and impatient to meet O Brian s Aubrey and Maturin. Hitchens may be a book that I will consult over an extended future, as I read more. Little by little I may be able to steal for my own use fragments of his extraordinarily rich cultural matrix.

Unacknowledged legislation? I am uneasy, and reminded of arty people for whom every painting is important. The 20th century is not unique in being graced by Wilfred Owen think of war in Homer, or the humanity of Montaigne. Given subsequent brutalities, are we to think of them as legislative failures? Does the recent absence of great wars owe more to Hiroshima, or to literature? Was Auden s Ogre laid low, perhaps, more by economics than by the quill?

Auden himself said that Poetry makes nothing happen . A J P Taylor thought that history was just for fun. The inventor of the essay was modest about its potential:

> *'This, reader, is an honest book. It warns you at the outset that my sole purpose in writing it has been a private and domestic one. … .I am myself the substance of my book, and there is no reason why you should waste your leisure on so frivolous and unrewarding a subject.* (Montaigne, 1580.)

Montaigne, just possibly, was teasing us here. Hitchens is spectacularly learned, stimulating certainly, but irritating too. Montaigne was serious but with a light touch. Hitchens mentions irony quite often, but portentously.

Alan Munro

The Case of Doctor Sachs
Martin Winckler
Seven Stories Press,
HB, 432pp, £18.99 (1 58322056 9)

IN December 1988 I was intrigued by a book review in the *BMJ*[1] by Ian Bamforth, of a French novel about the work of a GP in rural France. I struggled through *La Maladie de Sachs* with a growing conviction that it was an extraordinary and important work. And now available in a good English translation.

The novel follows the work of Bruno Sachs, a youngish, single and single-handed GP working in the village of Play and its environs, over a period of nine months. During this time we follow the evolution of many case histories of patients old and young, cantankerous, tragic, humorous, mundane and exceptional. We also follow the central case, that of Bruno himself, as he experiences a period of self-doubt and unhappiness, redeemed in the end by love.

Such a bald summary does no justice to the immense subtlety and complexity of the novel, which is distinguished by three particular stylistic devices. The first is the use of the second person, by means of which an intimate portrait of Sachs is built up through the words of his patients, receptionist, friends, and acquaintances. The second is the way in which these personal narratives are intertwined through the whole like the threads of a rope, weaving in and out of each other. The final device is the use of the interspersed reflections, in the first person, of the doctor himself.

What this remarkable novel achieves is a triumphant celebration of the central values of the GP in whatever culture or system they may practice: respect for the individual patient, absolute commitment to confidentiality, willingness to listen, and a determination to do what one can to alleviate distress.

It comes as no surprise that Martin Winckler belonged to a Balint group for many years: nowhere will you find a more convincing demonstration of the doctor as the drug than in these pages. You will also find a robust, if implicit, defence of personal medicine against the incursions of technology and specialism. In short, you will find a revalidation of your role, and God knows that is something to be celebrated in these troubled times.

Meanwhile, in France, a GP is approached by a patient with a promise to present him with a copy of the novel that has made such an impression. Please don t bother , he replied, I already have seven copies on my shelf ! I fear that our patients are less literate than the French, so I advise you to buy your own copy.

Dougal Jeffries

1. Bamforth I. *La Maladie de Sachs*. [Book review.] *BMJ* 1998; **317:** 1666.

Crying: the natural and cultural history of tears
Tom Lutz
Norton, 2001
PB, 352pp, £11.95 (0 39332103 7)

> *'Tears are the most substantial and yet the most fleeting, the most obvious and yet the most enigmatic proof of our emotional lives.'*

CRYING is a universal phenomenon and uniquely human. Crying has been recorded throughout history and yet we still have little understanding of the purpose of tears. The anatomy and physiology of tears is being uncovered; tears have been analysed and measured, and yet our understanding of just why we cry on particular occasions is still not fully explained.

In this book, Tom Lutz explores the history, philosophy and science of tears. From Aristotle via Hippocrates to Johnny Depp (*Cry-baby*), he charts the varying human interpretations of crying and those who cry.

Clinical practice involves an exploration of emotional as well as physiological reactions that we all try to understand and deal with. We know, or think we know, when people are crying because of sadness, loss, grief, embarrassment, happiness, anger or rage. But how can we deal with those tears in the most effective way? Empathy and understanding, the box of tissues and our expectation is that tears will stop. And they always do, eventually! But why do they start in the first place and why do they stop?

By extensive use of published literature in the fields of history, anthropology, sociology, psychology and philosophy, the author guides us through, often at high speed, current thinking on the act of crying. Differences in cultural practices and understandings sit beside explanations of why babies cry, why in some cultures women cry more than men and the way in which tears are used in a fictional context. He explores why weeping is becoming more fashionable in the western world.

The chapters on infant crying, the differences between men s and women s tears and the cultures of mourning are particularly helpful in increasing an understanding of this aspect of human behaviour. The explanation of differing cultural practices will help all who work in an increasingly cross-cultural environment.

By including contributions from so many disciplines this book provides both an instructive and thought-provoking view of crying that will help those who read it appreciate the importance of tears to our understanding of everyday life. The reference list is huge and will provide a wonderful resource for those who want to learn more about differing aspects of what Darwin called one of the special expressions of man.

Shipman and Climbie inquiries
As the timetable and list of issues for the Shipman Inquiry unfolds, the preparation work we have done so far has started to pay dividends. We are now clear that the inquiry will be run on legalistic lines which, while it may give it a great deal of formality, will ensure that it is run according to well known rules . The inquiry into the Victoria Climbie case will examine the background to this tragic case of child neglect and abuse that resulted in Victoria s death. We are likely to have a smaller part in this inquiry than in the Shipman case, but nevertheless there will be issues for us in the second phase of the inquiry (which will run in parallel with the first phase).

College Elections
The results of the election for the six vacancies among the elected Members of the Council to serve from 2001 to 2004 saw the successful candidates being: Dr Tina Ambury, Dr Richard Fieldhouse, Dr Iona Heath, Dr Has Joshi, Professor Mike Pringle and Dr Leone Ridsdale. Dr Val Wass, was elected Chairman of the Examination Board and will serve from the time of hand over from Professor David Haslam until November 2004.

Modernising the NHS
Colleagues from around the UK reported on progress on NHS modernisation in the UK countries. Particularly for activity related to Westminster, the progress has been interrupted by the General Election. We expect that when the new government gets to work, the new GP contract, GPs with special interests, the Primary Care Workforce Review, and the Senior House Officer Review will all resurface. While some of these may be mainly English topics now, we expect the direction they take to influence what happens elsewhere in the UK.

Mayur Lakhani and Sarah Thewlis had a helpful meeting along with representatives of other GP organisations with the English Health Minister, John Denham, prior to the election. The focus was on the College publication *Valuing General Practice*. It remains to be seen whether the theme of GPs requiring more time with patients, which has been constantly and tirelessly stressed, will leave any impression with the new government.

A paper from our Patients Liaison Group on Patient Involvement in the NHS is in preparation, although currently uncertainty surrounds the future of Community Health Councils in England, when their eleventh-hour rescue from abolition as part of the Health and Social Care Act did not occur.

General Medical Council Issues
The GMC had a major meeting on 22 and 23 May when it reached fundamental decisions about revalidation, the privileges and obligations of registration, the way forward on its structure, constitution and governance, and revisions to the seminal work *Good Medical Practice*. In most of these areas there is more work to do, particularly in the fitness to practice procedures. Consultation is due to start on a new edition of *Tomorrow's Doctors*. Importantly, revalidation has now been approved by the GMC something which we are very pleased to see.

We were less happy about the GMC s decision on the new edition of *Good Medical Practice* as our criticisms of the draft appear not to have been heeded. We feel the new edition will have lost the clarity and simplicity of the earlier versions. We will however work to align with it *Good Medical Practice for GPs* the document that will underpin revalidation of GPs in the UK.

The current President of the GMC and College Council Member, Sir Donald Irvine, announced his intention to stand down from the Presidency early in the New Year with his successor being identified in November 2001. The College has been proud that one of its most prominent members has chaired the GMC through what has been a particularly difficult period, but one which has produced significant change. We are drawing up for approval by our Council a process to determine Sir Donald s successor as the College s representative on the GMC.

Fellowship by Assessment (FBA): Administrative fee and eligibility
There was a paper from the Fellowship Committee looking at these two aspects of FBA. The first issue was the introduction of an FBA administrative fee and this proved to be relatively uncontroversial for Council. Council was happy to see a fee introduced because costs are incurred at an early stage in the FBA process. Some doctors who start the process do not complete it but at present there is no means of recovering the costs involved in those early stages.

There was a vigorous but good humoured debate at Council on the question of the eligibility criteria for Fellowship by Assessment which is currently set at five years continuous membership of the College. Various options were before the Council and those involving change would have enabled candidates for FBA to commence the process sooner than five years with various mechanisms beyond that regarding the actual award of Fellowship. The debate was concluded by a vote when a majority supported the status quo.

Resolution of GP Practice Disputes
Council was happy to approve a change in the way the President handles the small number of practice disputes which come forward to her each year. These disputes fall broadly into three categories: those that are of a pastoral

nature and where faculties may well be able to help the parties involved; those of a terms and conditions nature, to be referred to the local medical committee; and matters where disputes arise and there needs to be a more formal resolution procedure. Council approved the proposal that cases in the last category should be passed over to the Chartered Institute of Arbitrators with the cost of using their dispute resolution service being borne by the disputing parties. It will be for the President to determine the best way forward to resolve any practice dispute referred to her. We should be very grateful if Faculties could make their members aware of these arrangements. You should hopefully have the paper that was sent round prior to Council but if not, do contact Corporate Affairs for a copy by e-mailing **corpaffairs@rcgp.org.uk**

Decontamination of Surgical Instruments — Variant CJD

The Chairman of our Clinical and Special Projects Network, Joe Neary, reported on the impact of contamination of surgical instruments on GPs and in primary care. This has implications for single-use instruments and for the procedures for decontaminating instruments. The College has a specific link with this work as Lesley Southgate is serving in a personal capacity on a working party looking at these issues, in particular contamination, which can carry variant CJD. Joe Neary s paper provided some very helpful draft guidance for GPs. We need to work on this, involving the GPC to see how best to draw the issues to the attention of the Departments of Health and GPs. We expect there to be strong media interest in this issue even though the risks cannot yet be quantified.

Annual General Meeting —— 16th November 2001

Our Annual General Meeting this year is being held at the Paragon Conference and Exhibition Centre in London SW6. The venue proved very successful last year and we will as usual deal with appointments to Fellowship and presentation of awards followed by the James Mackenzie lecture. There will be some formal business for the AGM and if your Faculty has any business it wishes to be considered, please let me know as soon as possible, so that it can be included on the Notice of the Meeting. The Notice has to be finalised in September so that it can be circulated with the October issue of the Journal.

Maureen Baker

Next Council Meeting

Saturday 15 September, Princes Gate,

neville goodman

Election

Dear Mr Blair,

Don t be fooled. Voters didn t stay at home because they expected a Labour win, or because of overwhelming contentment. Turnout was down because you don t stand for anything any more. Given enough populism, voters realise that they prefer principles. I m a doctor, writing in a medical journal, so I ll confine my thoughts to health care. I ll tell you a bit about what I and my colleagues not just doctors, but all the many and varied and valuable people who work in the NHS really want. Forget waiting lists; forget waiting times. Stop banging on about heart disease, or cancer, or whatever the latest vested interest group have assailed you with and splashed across the newspapers. What we need is some mature debate about the future NHS.

You ve promised European standards of health care. On the surface that sounds good. You ve promised money to achieve it. For that we are grateful, and the continuing eclipse of the Tories may mean the public now realise that health must be paid for.

But what sort of health? The Europeans have the same problems as us, but to a lesser degree. Soon after the NHS s inception, there were worries that the introduction of steroids would bankrupt it. The only difference now, in 2001, is that there are many more potentially bankrupting treatments. The proposed solutions to the ills of the NHS, such as NICE and Clinical Governance and the host of other agencies erected to solve the problems of the moment, are only partial answers to the wrong problem. Yes, there are savings from abandoning useless treatments. There are variations to be evened out. Doctors need to keep up to date, even if we argue about how to ensure they do. All this is distraction.

Read the letter from Jim Wardrope in the *BMJ* of 2 June. A consumer model for the NHS will destroy it. Central command will destroy its staff as well. Just two examples will suffice. I ask you to think very carefully before legislating as opposed to persuading against ageism. And I really do ask you to reconsider PFI. Clinical evidence can be ambiguous enough; evidence in health economics for projects stretching 20 years sways with political outlook, which the facts are distorted to fit. So back to principles please, Mr Blair. NHS staff do not want taxpayers money put as profit into shareholders pockets.

Unless you wish to be remembered as a prime minister interested only in power and not in how you retained that power, the NHS needs careful, hands-off, public sector nurturing in your second term.

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our contributors

Kirsten Baker is a theatre practitioner, specialising in using drama with health care professionals and is a member of both Spanner Workshops and Progress Theatre. She is also a practising midwife.

Victor Bloom is an occupational health physician, now retired to Cornwall. He edited the *Journal of the Royal Society of Medicine*

Chris Butler was raised in South Africa, and studied medicine at the University of Cape Town. Until recently, he was senior lecturer in General Practice at the University of Wales College of Medicine. He is now Associate Professor in Family Medicine at McMaster University in Canada
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Phil Hanniford flocks, with other professors of general practice, in Aberdeen

William Hamilton was delighted to discover that humans share 50% of their genome with bananas. His banana was deaf too... **w.hamilton@cwcom.net**

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jill thistlethwaite

Having babies

MADRAS airport: my husband and I begin chatting to an elderly businessman about our delayed flight, the state of the world, and our trip to India. His evident delight at meeting two native English speakers turns to dismay when the conversation inevitably moves to more personal topics. Yes, we are a doctor and a teacher, no we don t live in London, yes we have been married for fifteen years, and no we haven t any children.

This is obviously a temporary situation he postulates, we look young enough after our three-week trip to procreate satisfactorily at some later date. But no, we state categorically, children are not in our future plans: we have decided to grow old together just the two of us.

In our own environment I sometimes get funny looks when I admit that I plan to remain childless. Perhaps the subliminal desire of my patients to see me do the right thing accounts for the regular rumour that I am pregnant. One patient was convinced that the reason I am now working part-time in the surgery is due to family commitments and regular maternity leave. Of course my peculiarity in not wanting to add to the world s overpopulation is not a unique foible. I see myself as one of a growing band of people, the next stage in the evolutionary chain, who respond to increasing human longevity and decreasing resources by deciding that our genes will not be missed if they die out in half a century.

Childlessness engenders many responses. The voluntary state draws comments of selfishness (as I read unforgettably on the letters page of *The Independent* a few years ago) in that we are letting the human race down in some way. Immorality is the view favoured by the religious minority, in that marriage (the only acceptable state for sex) is meant to be fertile. In some we engender envy as couples with children look at our uncluttered lifestyle and wish for just a few moments that going out wasn t linked to babysitter hell.

As a GP I can still have empathy for involuntary childlessness and the misery of the infertility cycle of investigation, treatment and regular disappointment. I believe that every couple should have the right to try to conceive one child and I feel I have enough sensitivity to understand the emotional pull of the overwhelming desire to raise a family. But some recent developments have made me wonder just how far our society is prepared to go to let women indulge their maternal urges. Surely we have to accept that we cannot always have what we want, that there are ethical and biological considerations that mean some women will be disappointed and unfulfilled.

At my age I accept that I will never be able to run the 200 metres in the Olympics. I might be able to run faster if I take anabolic steroids but I am resigned to the fact that as my life progresses I will run slower and slower and remain an armchair viewer of gold medal successes. Similarly, I believe that women older than myself have to accept that they will never conceive children naturally, and that scientific advances in fertility treatment should be reserved for women of a certain (childbearing) age. Children should be able to spend their late teenage years having fun rather than worrying about their parents impending dementia.

I just hope that I don t wake up in ten years time with an overwhelming desire for offspring. If I do please please don t indulge me and tempt me with a nice line in colour co-ordinated test tubes.