The Back Pages

viewpoint

A career in the community

THERE has been much discussion recently about general practitioners with a special interest those GPs who extend their remit into areas that have traditionally been the province of hospital specialists.

This leads us to think about hospital specialists whose remit extends into the community. Many specialities are now considering the training needs for a slightly different branch of their specialism. Liaison psychiatry, care of the elderly, community paediatrics, and community gynaecology are four that are more common.

Some of our future consultants may have had the opportunity to spend four months in general practice as a pre-registration house officer. Those doctors who are lucky enough to secure one of these prestigious posts find their training rewarding and stimulating. However, the review of the senior house officer (SHO) grade presents an ideal opportunity to consider how general practice could contribute to training programmes for all doctors.

If the review of the senior house officer grade reflects the previous reviews of higher training and the pre-registration year, basic training will move from posts and rotations to placements and programmes. This will create opportunities for experience in general practice and the values of primary care to be included in training programmes for specialist medicine, particularly that relating to community orientated specialities. Those intending working in the community would learn how to be an effective member of the health and social care team, contributing to the team but not needing to lead it. They would learn about the impact of illness on the family and the influence of social circumstance on health, encompassing the strengths of general practice of considering all illness in psychological, social and physical terms. They would learn how to manage care in the patients home, negotiating a care plan that is realistic and compatible with social circumstances. They would also learn about patient autonomy and that many prescriptions are neither cashed nor taken unless there is careful explanation and negotiation. Perhaps most importantly they would value the importance of being patient-centred, learning the skills of listening, observing, and reflection.

There are already SHO pilot programmes throughout the country, combining paediatrics with general practice or medical specialities with general practice. Some specialities; for example, palliative medicine already include general practice as an option in higher training. However, there is a danger that without commitment of the profession and our managers, time spent in general practice could be seen as a soft option or, worse still, serving time. Just as general practice needs SHO placements to be modified to meet explicit learning needs, so general practice placements would need to be modified to satisfy the learning needs of specialist trainees. They will need release to group sessions with fellow trainees of the same speciality, working perhaps with a specialist programme director and GP educator who will help them place their learning into the context of their intended speciality.

The review of basic training is also considering how each trainee should be assessed as having completed the placement satisfactorily. General practice will need to be involved in this process and consider the criteria and standards necessary for satisfactory completion. We already have skills in workplace observation and assessment; with our specialist colleagues we will need to clarify how specialist trainees can be assessed and how general practice should contribute to the annual review process.

The RCGP is already working with specialist colleges to agree standards for GPs with a special interest; maybe we should also be working with those Colleges that are moving to community based care. Together we could agree criteria and standards for specialists with a general interest, and how the Royal College of General Practitioners will be involved in the training and assessment of specialists who want to work in the community.

Jacky Hayden

"... magical superheroes protecting the world from parasitic aliens, shape-shifting politicians, and transsexual Brazilians"

Johnstone on essential comics for GPs, page 687

"Sure, things can and will go wrong, and yes, call me an old technophile if you must — but what an interesting time to be alive!"

Hodgkin coping with info-biological inadequacy syndrome, page 688

"Humans are well known to be story-telling animals, and never more so than at difficult times."

Murray *et al* on Patients as Poets,

contents

We asked for 10 recommended non-medical texts for aspiring general practitioners, and have got rather more than we bargained for ... herewith a selection. Each contributor can choose from any title by Radcliffe Medical Press. (Thanks again to Radcliffe for their generosity.)

Further entries gratefully received, via email, to **journal@rcgp.org.uk.**

Alec Logan

10 books

Nick Howlett

Captain Corelli's Mandolin by Louis de BerniŁres is the beautifully written story of a Cephalonian GP, Dr Iannis, and his daughter, Pelagia. Full of useful medical advice the returning soldier with seven separate dermatological problems; that love is a kind of dementia with very precise and oft-repeated clinical symptoms .

Paula by Isabella Allende. In 1991, Isabella Allende s daughter, Paula, contracted porphyria and fell into a coma. A year later she died. The book takes the form of a letter to Paula, written during the long hours at her bedside. Interwoven is Isabella s life story, and thus also the recent history of Chile. Achingly moving.

Perfume by Patrick S skind. The fabulously grotesque tale of Grenouille, born into 18th century France with the perfect sense of smell, but no personal odour. He becomes apprentice to a leading perfumier, then endeavours to create the ultimate perfume, adopting increasingly gory means of capturing smells. Part Charles Dickens and part Stephen King.

The Complete Sherlock Holmes by Sir Arthur Conan Doyle is arguably the finest work of literature by a GP. There is much to learn from Holmes powers of visual deduction. My favourite is the clever diagnosis of a well-marked case of pseudo-leprosy or ichthyosis in *The Adventure Of The Blanched Soldier*.

The Name Of The Rose by Umberto Eco. My all-time favourite book. A perfect combination of medieval whodunnit and learned study of hereticism, along with lots of evidence-based 14th century herbalism: the use of the snakeroot rhizome to treat diarrhoea and certain female complaints.

I Bought A Mountain by Thomas Firbank. As a rural GP, this is my favourite book about farming. In 1931, the author, a Canadian, buys Dyffryn Farm, encompassing much of the Glyders in North Wales, and struggles to run a 2400 acre sheep farm without any prior experience. Very educational and very moving.

An Instance Of The Fingerpost by Iain Pears. The beautifully crafted story of the murder of a 17th century Oxford academic, described by four witnesses a brilliant young Venetian GP (responsible for the first blood transfusion), the chief cryptographer to Cromwell, the son of a Royalist traitor, and one of the victim s fellow academics.

The Man Who Loved Only Numbers by Paul Hoffman. The fascinating biography of Paul Erdos, a wonderfully eccentric pure mathematician. Erdos had very few belongings, and no home. He would turn up at fellow mathematicians houses unannounced, declare My brain is open , work for a few days, then move on, writing 1475 academic papers in the process.

Miss Smilla's Feeling For Snow by Peter Hłeg. The perfect thriller for anyone with a scientific mind. Set in Copenhagen and Greenland, the heroine, Smilla Jasperson, is an expert in the varied forms of snow and ice. Packed with geophysics, meterology, pathology, anthropology and much more.

And finally, ***River God*** by Wilbur Smith. Wilbur is the man for holiday reading, producing brilliant boy s adventure yarns, generally set in Africa. *River God* is a saga of Ancient Egypt, as the new Queen Lostris and her faithful eunuch slave Taito flee from their enemies up the River Nile into the highlands of Ethiopia.

Jonathan Evans

Just as the faithful will see vindication for their religious beliefs in all things, it may be possible to draw lessons from any literary source. It may be possible to work from a list of medieval tomes, but it is not necessary. Since, for the next few decades, our future GPs will have been born in the 20th century it would seem reasonable to suggest a more contemporary reading list.

Literature s greatest strength is to illuminate areas of the human condition outside our own experiences. Ruth Picardie s ***Before I Say Goodbye*** and John Diamond s ***C — because cowards get cancer too*** superbly document life with terminal illnesses. Of particular interest to GPs would be those books that provide us with insights into patient s lifestyles far different to our own

Trainspotting by Irvine Welsh would probably qualify for most of us and Caroline Knapp s ***Drinking*** a love story for rather fewer.

Authors will often (or perhaps, always?) be more articulate than writers of medical texts, so may be better able to describe particularly difficult areas of medicine, such as the psychiatric experience. ***Freefall*** by Tom Read is an account of emerging paranoid psychosis and its effects on his family; Emily Colas ***Just Checking*** charts her obsessive compulsive disorder and rings too many bells.

Worthy volumes have traditionally been used to explore the role of the doctor within society A J Cronin s ***The Citadel*** and Albert Camus ***The Plague*** ought to be on any medical reading list.

Ultimately, the real role of literature must be to entertain, and if the above list were insufficiently stimulating and our aspiring GP was just leaving school, Will Sutcliffe s hilarious ***Are You Experienced?*** will do that while inoculating them against the boasting of History of Art students using their long holidays to find themselves in the Third World.

Finally, of supreme sociological significance, the complete scripts of ***The Royle Family*** can provide examples of every strand of Helman s Health Belief Model, as well as Nana s ongoing tutorial on bowel problems. The whole of general practice in one volume.

The education of a gentleman my foot...

Gwen Delany

To qualify for the list, what should books give? Pleasure first; and second, they must give another, any other, point of view: from a world out there where medicine is only one of a zillion other things. I would suggest...

For Your Own Good Alice Miller Everyone s point of view: a child s. You could even stop reading after this. However, the following illuminate the theme:

The New Summerhill by A S Neill, and ***The Teenage Liberation Handbook*** by Grace Llewellyn

And for something completely different ...

The Republic, Plato. Much of it repels, but there are two shining exceptions: Socrates prognosis for the Just (Wo)man (Part I, Book II, paragraph 4) and the Simile of the Cave (Part VII, paragraph 7): We can see if we want to, or take refuge in not seeing ...

Declarations of Independence Howard Zinn. How to be a Just (Wo)man all the same, in spite of Socrates dire warning: and change the world just a bit. It s been known...

And at the rush...

The Grapes of Wrath John Steinbeck

The Jungle Upton Sinclair, both of which dish the dirt on market forces and economic migrants Plus...

Any novel.
Any history.

And to validate the very idea of lists like these (my all-time, top five/ten memorable split-ups/dream jobs/episodes of Cheers):

High fidelity by Nick Hornby.

10paintings

Honor Merriman

Let me share with you another list, one of paintings. I ll give you my favourites in the expectation that you will visit some of the collections where the originals are on show and then formulate your own top ten. These images will provide insights into yourself and those you work with. They will encourage reflection in situations where you might have previously have made ill-judged decisions. You may wish to use the scanned images of your own list as a screen saver on your computer to refresh your mind between consultations.

The Adoration of the Kings Pieter Bruegel the Elder. (National Gallery, London). The vulnerability of the Christ Child and His Mother stand out clearly, the surrounding crowd bear gifts but are there for their own ends. Think of this when you next see a mother and unwell baby.

Self Portrait, 1633 Rembrandt. (Louvre, Paris). An affluent and confident young man establishing his career, but he has doubts. He has used the opportunity to reflect his own image as one in which he considers his present state.

Self Portrait, 1661 Rembrandt (Kenwood House, London). Rembrandt presents himself as the master painter of his age; however, examine his expression more closely. Painted seven years after the death of both his wife, Saskia, and Titus, his son, is this man content or is his own mortality only too clear to him?

A Bar at the Folies-Bergère Edward Manet. (Courtauld Institute, London). This was Manet s final completed work. He painted life as he saw it in Paris in 1881 and I am sure he wanted the viewer to think about the life of the young woman in the centre of the canvas. He would also have wanted to give pleasure to the viewer in the colours and impressionistic style.

Scene on the Loire (1826 1830) J W Turner (Ashmolean, Oxford). Tranquillity. Mastery of landscape. A taster for the Turner Collection at Tate Britain.

Christ of Saint John of the Cross (1951) Salvador Dali (Glasgow Museum of Religious Art). A painting by one of the greatest exhibitionists and poseurs of 20th century art, it can arouse a new vision of what faith can mean. A new way of looking at where we are in relation to our beliefs.

Broadway Boogie-Woogie Piet Mondrian (Museum of Modern Art, New York). Art can be fun.

Marriage a la Mode William Hogarth. (National Gallery, London). More than a melodrama in six scenes, an insight into life then that helps us understand life now. If you liked these then go to Sir John Soane s Museum to see *The Rake's Progress* (and much else).

Dylan Thomas Augustus John. (National Museum of Wales, Cardiff). The subject and the artist are both enigmas but what has the artist added to the Welsh poet? More food for thought.

L'Escargot Henri Matisse. (Tate Modern, London). Fun but more complex than it first appears and worth viewing more than once, like so many things.

Enjoy!

10comics

Chris Johnstone

From Hell Alan Moore

Alan Moore is from Nottingham and is generally regarded as the man who reinvented comics in the 1980s, dragging them from sweaty, hormonal adolescence into sweaty, cynical adulthood. Three of his comics are in my top ten and his best one is the most recent. *From Hell* reworks the Jack the Ripper story. Extensively researched, Moore even includes Iain Sinclair s involvement of Hawksmoor and his brooding churches. Beautifully illustrated by Scot Eddie Campbell, and a perfect entrance to the world of comics for adults.

Our Cancer Year by Harvey Pekar and Joyce Brabner is the story of Pekar s diagnosis and treatment for cancer in Cleveland. His partner also tells her story of their cancer. Horribly honest and terribly moving. A personal insight into suffering and relationships.

Usagi Yojimbo by Stan Sakai. Set in 16th century Japan, this ronin adventure series stands out for two reasons the eponymous hero is a rabbit (all the characters are different animals), and that it is a masterwork of story-telling. Sparse dialogue, impeccably sourced, and deceptively simply drawn.

Swamp Thing by Alan Moore, catapulted Moore to fame in the US. He took a fairly banal superhero (a monster that fought villains by controlling vegetation) and turned him into an earth-spirit fighting for the life of the planet. Illustrated spectacularly by Bissette and Totleben, it was an instant hit and comics grew up. The ultimate eco-warrior.

Collected Crumb by Robert Crumb. In the 1960s Crumb was the underground artist of the hippy movement. His comics lampoon middle-class America, drug enforcers, and all puritans. He was also obsessed by Amazonian women with huge buttocks and even bigger calves. And also with what he could do with these powerful women therefore not all his work is available in the UK, but anything by Crumb is a gem to cherish.

The Invisibles by Grant Morrison. Morrison is one of the most intelligent writers in modern comics and he puts his prodigious talents to best use in this series of magical superheroes protecting the world from parasitic aliens, shape-shifting politicians, and transsexual Brazilians. Mind-expanding, schedule A comics. Not to be read sober.

Maus by Art Spiegelman, describes his father s experiences under the Nazis in the Second World War. One of the most moving accounts of the ghettoes and camps I have read. The Jews are mice and the Nazis cats. It sounds puerile, but manages to convey the horror in clear, clean pictures that brought tears to my eyes.

In ***Watchmen***, Alan Moore does to comics what Vietnam did to the American psyche. He takes the superhero of old (decent, kind, virtuous, all-American) and describes what we might be like if we really had superpower over other people. They behave as badly as anyone else does, but are quicker, stronger, higher, etc.

2000 AD is Britain s weekly fix of science fiction and futuristic violence. Judge Dredd has been doling out instant justice for over 15 years, fighting any criminals, aliens, and dinosaurs that don t obey the law. And he is the law. Be pure, be vigilant, behave.

Kane by Paul Grist. This delicate British comic from Dancing Elephant Press (PO Box 2362, Wells, BA5 1YQ) illustrates the story of Detecive Kane on his return to work in New Eden precinct. A black and white comic of wit, sensitivity, and humour.

fututrology

Postcards from the 21st Century

Joint articulation – local authority services are essential for health

This is the sixth 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.*

THERE is an interesting training exercise that asks people what the three most important things for their quality of life are, and the responses are always fairly similar. Most people come up with things like happy families, an interesting job, financial security (it is always refreshing how few people actually want to win the lottery) and always, top of the list, is health.

No great surprise there, I suppose, but it is reassuring to those of us whose work is concerned with health improvement and protection that the value of good public health is genuinely recognised by the vast majority. Your money or your life? Take my life, I m saving my money for my old age!

Working in local government, where I lead Oxford City Council s Health and Environmental Promotion team, the interesting issue is that while the value of public health is definitely recognised, changing that recognition into practical services, resources, and health-improving action on the ground is another question. My role is to use my team to effectively nag, cajole, and persuade my colleagues throughout the authority to ensure that the services that the Council provides are maximising the health and environment of the people of this historic city. Health, in its broadest sense, is the responsibility of so many public and private organisations (many of whom operate outside of the conventional health economy), that it ends up being nobody s priority and consequently gets overlooked. So another of my roles is to work with other organisations, particularly the fledgling Primary Care Trust (PCT), to ensure that as many organisations as possible are marshalling their resources in favour of sustainable health improvement and environmental protection.

While local authorities were created to protect public health, that original clear focus has now been lost and it is difficult to point to the strategic health improvement thread that still runs through so many services provided by the local council. This lack of focus may mean that opportunities are lost, resources are not invested correctly, services poorly targeted and any prospect of coherent partnership working is made extremely difficult.

Unfortunately, the Department of Health itself often seems to confuse things further by assuming that all Councils are unitary authorities (i.e. that County and District Councils are co-terminous). Worse, it frequently seems to think that responsibility for health issues lies solely with Social Services.

So what is the role of your local authority in improving health? Think of the services that your council runs: environmental health, planning, refuse collection, street cleansing, parks, swimming pools, council housing, education, street lighting, transport planning, Social Services, and many others of course. Now imagine the impact on health if all of those services no longer existed and you soon see how vital local authorities are in health improvement.

So while it is impossible to metaphorically push a button in your local council and see the exact links to health highlighted, it is clear that the services provided by local government have a large impact on the health of the area they serve. Planners and PCTs ignore these links at their peril.

But does your local council realise the importance of linking with the new health bodies such as PCTs? Have they been involved in discussions on your Health Improvement Programmes? Are there any joint working arrangements between the Council and Primary Care Trust? Do local health plans acknowledge the contribution of non-health organisations to the state of the area s health? If you have identified a particular health issue in one part of your area, do you know which part of the local Council may help to influence this issue?

And of course the same questions need to be asked within local authorities to make sure that public health issues are raised up the agenda of every Council service. This is all the more important as it is no longer guaranteed that professional training for planners, swimming pool and leisure centre managers, and housing officers will adequately cover public health issues and specialisation within services means that the broader agenda is likely to be neglected.

We all find it difficult sometimes to raise our heads above the in-tray and I can hear the collective groan from numerous health service workers up and down the land as they anticipate endless futile meetings on the meaning of health improvement and piles of paper generated by partnership projects. This has certainly been a common experience to date, because working in new ways is difficult and does take time to get right. But I would argue that it is worth investing the time to make partnership working succeed because the long-term benefits are so great. Fail, and patients will still find their good intentions to lead healthier lives frustrated as local shops close, there is nowhere to take a stroll, the roads are deathtraps for cyclists, and the air quality is so poor that you need an iron lung with you every time you venture outside.

Joined-up thinking is a fairly obvious concept, but finding the time to achieve it in practice is another matter. I am reminded of a conversation with a leisure centre manager who complained that he was now being asked to run his pool in an environmentally friendly manner, ensuring that people s health is improved, achieve best value, and help reduce crime by keeping bored teenagers off the streets. And all he wanted to do was run a good swimming pool.

Further reading
Campbell F (ed), on behalf of the Democratic Health Network. Building Health Communities. *The role of local government in health improvement.* Local Government Information Unit, 2000.

Understanding the role that non-health public services play in the health economy helps to tackle the broader determinants of health. It can also make it easier to reduce inequalities. Equally, it is important to make sure that we are targeting resources to where we can genuinely make a difference there is little point in expensive meetings with your local council to discuss, say, oral hygiene or teenage pregnancy if there is precious little that the council can contribute to any solutions. True, local authorities do have an important representative role and can therefore make a claim to have an interest in almost every local issue, but sometimes it is worth checking what practical difference they can actually contribute.

But where there is a true confluence of interests, then the potential for genuine partnership working between non-health public services and the mainstream health economy is huge and the rewards should be great. The new flexibility afforded by the Health Act and Local Government Act present a real opportunity for pooling budgets and ensuring they are spent in a way that benefits local people. At Oxford we have a good track record of improving homes in the city by installing efficient central heating systems and thermal insulation, using health needs assessment as a key criterion in how these resources are allocated.

But of course there will be obstacles to overcome. Getting professionals to understand each other s actual and potential roles in health improvement is a major barrier to good partnership working. The differing cultures, priorities, training, and career patterns tend to accentuate the differences rather than recognise the similarities in work. At Oxford we are currently in the middle of a short exercise intended to help overcome some of these institutional barriers. A group of primary care staff (health visitors, community nurses) are being invited to spend time accompanying local authority staff for approximately one week, with funding being made available to pay for their cover. During these secondments the staff witness how the local authority deals with public health issues and hopefully the potential for improved joint working will be increased as a result. Often organisations deal with the same client groups, but do not get the opportunity to see how this is done and where improvements could be made.

If this type of practice were to become more widespread then it would hopefully reduce the impact of the cultural baggage that we all carry when we represent our organisations at joint partnership projects. By understanding the contribution that all organisations make to improve public health we can harness those resources more effectively and genuinely make a difference to people s health and well being for the benefit of all.

Tom Knowlands

Complexity is quadratic

Time was when things went slower: documents had to go to the typing pool, committees took decisions with deliberation, and communication went, quaintly, by post. Now the churn is much faster: word processing means I do my own typing and work at weekends, the fax spills onto the floor, there is no escape from the bleat of the mobile phone and we live under the tyranny of e-mail. In short, the bottleneck is now you and me.

Among other things, all this communication means that patient services move faster. Length of stay declines and throughput rises. Convalescent care that previously happened in hospital now falls on relatives and community services.

The sheer volume of communication is astounding: in 1996, US hospitals were generating 30 000 internal e-mails a week — and of course this is mostly new communication that co-ordinated that faster, more intensive through-put.

Such speed has its costs. Shenk characterises two new phenomena: Info-biological inadequacy syndrome — ‘a form of anxiety brought on when a person wishes he or she could absorb information at a rate somewhat faster than the level that was hard-wired into human DNA back in the Palaeolithic era’. And ‘fragmentia’, a relatively new cognitive disorder where one feels cut off from a sense of wholeness because of excessive exposure to incomplete concepts and ideas which are never….

But enough of that! Time presses on and new projects arise like dragon’s teeth around us. Each new policy, each completely reasonable call for partnership, breeds another initiative. And, inescapably, the costs of co-ordinating all these rise geometrically — five projects means, potentially, 25 interconnections to be attended to; six policies yields 36. We do not suffer because we are stupid, inadequate or lazy, we suffer because complexity is quadratic.

In part, we are transfixed by our particular time in history. Central planning and bureaucratic organisations are failing in the face of vast, technologically-driven change that only the market seems capable of handling. But in the larger sweep of history it is likely that we are simply living out the last years before the next generation of software begins to manage and generate organisational complexity. What awaits us then is not AI (artificial intelligence) but IA — intelligence augmentation — software that can, say, use the Internet to seamlessly inform clinical behaviour, and gathers data about encounters with patients as effortlessly as Tesco gathers our shopping habits to its breast. Sure, things can and will go wrong, and yes, call me an old technophile if you must — but what an interesting time to be alive!

Further reading

Shenk D. *Data Smog*. Abacus Books, 1997.
Gleick J. *Faster: the acceleration of just about everything*. Abacus Books,1999.

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poesy

Patients as poets

'Poetry is the shortest emotional distance between two points; the writer and the reader.

Robert Frost

As part of a larger, qualitative study, our palliative care researcher in Edinburgh has recently been asking patients with advanced lung cancer and severe cardiac failure about their experiences of coming to their diagnosis. In a series of unstructured interviews she encouraged people to speak in their own time and on their own terms. Once patients realised she had time to actively listen to their accounts, they tended to give not short responses but complex stories. Quite often, these were extended narratives. This is scarcely surprising, since humans are well known to be story-telling animals, and never more so than at difficult times.

Having enabled the participants to bring forward their stories through our please tell me about it approach, we then had to look at ways in which we could learn from these and give full credence to their importance. The more we studied these stories the more certain we became that we shouldn t simply fragment and decontextualise them by coding, but that they could only be fully understood as complete narrative units. So our researcher, utilising her background and experience in narrative analysis and the classics, began to look through the transcripts for narrative markers and retained these sections as whole units.

We also thought about the transcription process itself and came to see it, too, as a crucial, yet problematic, part of our interpretative practice. Transcription is neither a transparent nor an atheoretical process, but embodies the epistemological assumptions underlying any study. Although there is a tendency to assume that we speak in prose, there is an argument that the stanza is, in fact, the universal unit of human speech, and that we all speak in poetry. Once we looked at the transcripts again from this perspective, we were amazed at how readily they fell into the rhythms and cadences of poetry. Once sensitised to this, we found ourselves listening to the interviews differently, writing them up differently and responding to them differently. The patients came dramatically alive, voicing their experiences and their hopes.

'Poetry is the spontaneous overflow of powerful feelings: it takes its origin from emotion recollected in tranquillity.'

Wordsworth

Words can provide a window into other peoples experiences, but the form and meaning of words are crucially linked. Consequently, if we mistake the form in which research participants speak to us, the danger is that we also mistake their meanings. Considering transcripts as poems and there are some epic narratives has allowed us to better hear patients voices and may enable a more holistic understanding of our patients experiences.

'We had the experience, but we missed the meaning.

T S Elliot

We would like to present an example from the study, which we have anonymised and transcribed as poetry. These accounts are taken directly from the interview transcripts; the only change that we have made is to abridge them slightly. They are reproduced here with the permission of the wife of the late Mr MM.

We think that this approach to transcription results in poetry that could be useful for undergraduate and continuing medical education to emphasise the patient perspective.

Scott Murray
Marilyn Kendall
Kirsty Boyd
Allison Worth
Frederick Benton
Hans Klauser

Project funded by a grant from the CSO, Scotland

It takes over your life

by M

When I found out
It was a shock.

Well, going back,
End of October,
I thought I had,
There was a lot of flu
On the go,
I thought I had,
The flu.
I felt terrible.
This went on
For about three weeks.

I went to the GP.
'Oh, take paracetamol,
It's a virus.'
I went back
About a week later.
I said, 'Look,
I'm really terrible.'
'Oh, it's okay
It's a virus.
Just carry on.'

So I went back
To the doctor,
I think it was
Eh, 30th December.
I ended up going
To the doctor
The day before Hogmanay.
She right away said,
'No,
This has went on too long.'
It was a different,
It's the same practice,
But a different doctor.
……..
She done all the tests,
Sent me for an X-ray
Along to hospital K.

I got a phone call
The next day,
From the doctor, saying,
'Go and collect
Your prescriptions.'
They had found
A shadow on my lung.
But they obviously thought
This was some infection I had.

So, there was a holiday period,
The Hogmanay and that,
So I had to go back and see her
A week later,
Once all the tests were done.
So I went in and seen her,
And she looked at me and said,
'You know,
You're a very sick man.
We don't know
What's wrong with you.
It could be TB.'

Which was a shock to me.
But I thought,
Well, TB.
She said,
'It's curable now.
It takes a year and a half,
To control it.'
And she arranged for me
To go along to the clinic
The following week.
Because everything was done
Very quickly
After that.
……..
So I went along
Got this,
Came out,
Lying in my bed in the hospital,
And about the back of five
The doctor came along.
He said,
'I'm the chap that did your thing,
And I've got some bad news
For you.'
He said,
'When we put the tube
Down your nose
And into your lung
We found
A massive tumour there.'

So,
It's sort of,
Oh, Oh, Oh,
And my philosophy in life is,
If you've got it,
You can't do much about it,
You know?
There's no point.
You feel like
Oh, crying there and then,
But I thought,
No.
That's it.

My wife came up.
They told her.
She was more upset
Than I was.

But he said,
'Just to confirm,
It's malignant,
Come along to the clinic
On Friday.
We'll run tests on it,
And send a bit of it
Away.'
And I went back on Friday,
And he said,
'Yes,
It is cancer.'
And he says,
'One of the cancers
You don't really want,
Is that one.'

Seemingly it's a bad one,
You know?
There must be different forms
Of cancer.
…….
As I say, the shock
Came back then.
I went to my bed.
I just felt like
Having a wee cry at that time,
And I thought,
[I feel my eyes
Watering up the now]
But I thought,
Oh well,
What's the point?
…….
I never knew that cancer
Would take over your life,
And it is,
It more or less takes over
Your life.
It's like,
To me,
It's like something
With a mind of its own,
And it tries to control you.
It tries to control
What you eat.
It controls
To me,
The temperature
Of your body,
Because you can sweat
One minute,
And freeze the next.
It takes over your life.

So going along
To start my treatment,
My first treatment,
Was, not grim,
But I mean,
You're still ill
With the cancer,
You're still feeling
Really, really down.
You're getting the treatment
And saying,
'This is going
To do me good.'
But at the same time,
I think the first treatment
Is really hard on you,
Because you've got
The two illnesses,
The chemotherapy
And the illness.
The pain
From the two of them.
…….

It takes over your life.

david mazza

Palliative care in Delhi

THE three members of the palliative care team sit in row on a low-lying charpoy. Each of us eats our bowl of ice cream and we smile at our patient who has advanced head and neck cancer. His forcefully persuasive hospitality is typical of the people we meet in Delhi.

The complexities of life here also influence any attempts to develop palliative care. In a city where there are so many choices of health care, and there appears to be an MRI scanner on virtually every street corner (only a slight exaggeration), the benefits of palliative care are difficult to sell to both doctors and their patients. For one thing, there is no money in it. Come to us and we help add quality to the time that you have left to live is not an attractive advertising slogan when everyone else is offering a miraculous cure. Yet 80% of people with cancer here present when a curative procedure is no longer possible.

One of our patients lives with his family under a tree. He sold his house in Bihar so that he could come to Delhi for treatment of his metastatic lung cancer. Despite the expensive chemotherapy that a private hospital kindly asked him to purchase, the cure, which he so desperately hoped and prayed for, has predictably not materialised. When he dies, as he surely will in the next few weeks, his family will have little option but to continue their existence under the tree. The tragedy is that, as he faces death, he is only too aware of this.

There is another fundamental difficulty that limits our effectiveness as a palliative home care team. Although anyone can buy virtually any drug, from antidepressants to benzodiazepines (and on through the alphabet) over the counter without any difficulty, it is virtually impossible for a doctor to prescribe morphine. The narcotics regulations demonstrate Indian bureaucracy at its most formidable. My life has already been shortened by sitting in several different government offices, waiting for meetings that result only in frustration.

And yet, among the difficulties, the principles of palliative care can still bring benefits. Today, I spent some time with a young woman with advanced ovarian cancer who knows that her time is limited. She has talked about being frightened of dying but not of death. She has made some sense of the way her parents treated her as a child. She has been enjoying her relationships with her partner and her family. During the last few weeks, I have seen her anger and fear fade. Today, her face demonstrated the peace that her words described. She laughed when I finally accepted a cup of tea at the third time of asking.

Domestic violence and health: the response of the medical profession
Emma Williamson
Policy Press 2000
PB, 220pp, £14.99, 1 86134215 2

DOMESTIC violence is prevalent throughout the social spectrum, with some studies reporting rates as high as 30 40% of women experiencing abuse at the hands of a male partner or ex-partner. The term includes psychological, emotional, and economic as well as physical and sexual abuse, so as well as physical injuries women suffer other health problems, especially mental health problems. Violence often begins or escalates during pregnancy, with additional risk to the health of the unborn baby. Women often initially present at accident and emergency services or to their GP; however, many present to a range of health services including primary care, mental health, maternity, gynaecology, and family planning services with other consequent health problems. However, both the abuse and its link with the consequent health problems are often missed at such consultations.

Health care professionals fail to identify domestic violence because they do not ask women about it. Most healthcare professionals have had no training in this area and they do not ask for various reasons. They may be unaware that it is so prevalent, may be afraid of causing offence or feel they lack the skills to deal with a problem for which they think they can offer little, apart from advising the woman to leave her partner.

The reason that they fail to ask is not because they are all nasty uncaring people! With increasing recognition (albeit rather tardy) of the impact of domestic abuse on health and the consequent implications for those providing health care, many professional bodies at under and post-graduate levels are addressing the issue and drawing up training programmes and management guidelines. The health professions are also increasingly contributing to research into the problem.

This book is not written by a healthcare professional but professes to be intended for use by a range of health professionals . It is based on research into the experiences of women who suffer abuse and the responses by the various healthcare professionals they encounter. It begins with an overview of the problem and a review of research into domestic violence. It then presents the results of the current study looking at women s experiences, the healthcare professionals responses and perceptions, and makes recommendations in the light of both sets of findings. The book concludes with a summary chapter that includes useful information which can be accessed by health professionals

This book may well be of interest to those with a specialist interest in this area. Sadly, I think it is unlikely to be a useful resource for the average health professional seeking to acquire or improve basic knowledge and skills or indeed to be widely read by such individuals. While the women s accounts are eloquent and moving, the book is otherwise fairly impenetrable (70-word sentences, that require several attempts at reading, do not assist comprehension!) and includes lots of jargon. For example, we are told that the research used a feminist methodology ; however, this is not defined! More importantly, the initial tone which is not exactly sympathetic to the difficulties faced by health care professionals is quite likely to antagonise and produce a defensive reaction from the very professionals it hopes to assist. Communication failures between services are not solely attributable to health care professionals personal shortcomings. It is also pointless to encourage routine enquiry in the absence of adequate back-up services. It is important to recognise that the hard-pressed health care professional who asks the question, and in identifying abuse opens the floodgates, needs more than an answering machine at the local under-resourced Women s Aid office. Such an experience is unlikely to encourage routine enquiry in the future. Obviously, this doesn t explain all inadequacies in the health care response to domestic violence but it is important to recognise that the problem is a complex one that no amount of awareness, training, and attitudinal correctness will overcome. Similarly, while a multidisciplinary approach is essential, this must be developed within a strategic framework with adequate resources.

The book does finish by looking at training issues and a multidisciplinary approach to management; however, there is a lot of reading before this section. Consequently, this book is unlikely to meet the needs of the average busy health care professional who simply needs basic information about domestic violence. Such an individual needs to know about prevalence and patterns of abuse, how to identify it, how to initiate management, and how to collaborate with other agencies to which women could be offered referral. Fortunately, a number of helpful publications are already available, including, for example: *Domestic Violence: the general practitioner's role*, by Iona Heath (In: Royal College of General Practitioners Members Reference Book. London: Sabrecrown, 1992).

Mary Hepburn

Managing Chronic Obstructive Pulmonary Disease in Primary Care
Antony Crockett
Blackwell Science, 2000
PB, 144pp, 0 63205609 6

LAST summer, I suggested to one of my septugarian patients that we might fit an oxygen cylinder to her electric golf-cart. The tax had been reclaimed when she bought it the previous season, around the time long-term oxygen therapy was introduced for her COPD, and she had managed to maintain her handicap. Although she had accepted the cart, she was reluctant to demonstrate in public that she required supplemental oxygen therapy.

Sadly, she died (fortunately from a catastrophic cerebrovascular accident sparing her further loss of functions) before being persuaded that a portable oxygen cylinder was admissible in medal rounds. However, we were both grateful that, despite her severe airways disease, she had managed to preserve so much quality in her life.

Knowing our patients real agenda is the essence of general practice, and Antony Crockett stresses the need to approach COPD in a holistic manner.

He also recognises that COPD is currently where asthma was 10 years ago, and his logical structured approach should encourage GPs to provide structured care for COPD from where it can best be delivered the community.

Crockett recognises that most GPs are not as comfortable with COPD (perhaps due to a degree of therapeutic nihilism) but this book should provide the structure and confidence to tackle a disease that WHO considers the fifth most important worldwide, and which results in double the actual number of consultations and fifteen times the mortality of asthma.

If you do not already have a spirometer, buy one with your next clinical governance money and if, like me, you have one (but until now no COPD programme) use it more effectively. Adopt the team approach, empower your practice nurse, use your other available resources particularly community nurses, to help provide home assessment for the housebound. You may struggle to provide nutritionists and physiotherapy but this book will encourage you to set up an accurate COPD register and will show you how to audit easily the important facts, the necessary processes that you will implement and, ultimately, you might see a difference in outcome a few years hence.

Cliff Godley

in brief

Two events this summer restore one s faith, partially, in the grand ol US of A. First is the defection of one senator, John Jeffords, from Republican to Democrat, throwing a spanner in Dubya s legislative program (sic). A constitution that constrains the Executive in such a fashion is admirable, and such checks could be usefully copied on our side of the Pond. And second? ***Malcolm in the Middle*** (BBC 2, Friday evenings), which defies the axiom that nothing can follow The Simpsons . Nominally a children s comedy series, but brilliantly written, sharply characterised (especially the mother from Hell), and darkly hilarious. All of this packed into 25 minutes. Particularly recommended for boys aged 4 to 40.

And as you re all heading off for the beach, a weighty tome to threaten your luggage allowance, namely ***The Rules of the Game: Jutland and British Naval Command***, by Andrew Baxter (John Murray, PB, 708pp, £15.99) a magisterial, account of the Royal Navy at Jutland in 1916, and why the German High Seas Fleet was not annihilated as expected. The usual suspects faulty gunnery and ammunition, inadequate armour protection, incorrect deployment of force, lousy signalling, and rigidity of tactical thinking. Baxter s book is in three sections; he interrupts the chronological description of the battle with a long and brilliant dissertation on the late Victorian navy. Nelsonic vigour waning in a century of peace in the long calm lee of Trafalgar . The ability of officers to think for themselves was eroded by precedence, patronage and the corrosive effect of freemasonery and excessive deference to Royalty. There are interesting parallels to be drawn between over-regulation of the Navy, and of doctors a century later herewith the *Saturday Review* in 1894:

> *'To tell an officer what to do and leave him to decide how to do it, by the light of proper professional knowledge, which is the way to form self-reliant men with alert brains, is not the object of a modern Goverment Office. On the contrary, the aim is apparently to have an instruction for everything, so that the Office may have something to appeal to for the purpose of showing that it is not to blame. Of course these things are subject to continual modification and amendment to modifications, till it has become a commonplace that no officer can know all the printed instructions by which he is supposed to act...'*

Substitute officer for general practitioner , instruction for guideline or, even better, National Service Framework , and you have a perfect teaser for hot sticky nights sipping manzanilla as the sun sinks into the Mediterranean. Are we to share the subsequent fate of Beatty s battlecruisers , or cultivate creative insubordination?

Alec Logan

greenhalgh s books

1. Enduring Love *Ian McEwan.* Award-winning novel about the precariousness of human relationships and the devastating social impact of madness. McEwan cleverly explores through his main characters the contrasting worlds of artistic interpretation and objective, experimental science and asks where medicine belongs.
2. Dr Pascal *Emil Zola*. Dr Pascal believes that all human behaviour can be explained by science. Proving this becomes an all-consuming passion that ultimately destroys him as the boundary between his professional and personal lives disappears.
3. Four Novellas *Samuel Beckett.* These distillations of *la condition humaine* are a revelation. Beckett s scalpel-sharp prose is at once simple and profound, agonising and hilarious and utterly compulsive.
4. Mummy Laid an Egg *Babette Cole.* Provides a kid s eye view of sex education and why adults are often not very good at providing it.
5. The Small Matter of a Horse *Charles Van Onselen.* The sociology of apartheid brilliantly transformed into story form by a humane Afrikaans academic, via an account of the life of the South African legend Nongoloza Mathebula.
6. The Alchemist *Paulo Coehlo.* A superficially simple tale of a boy who seeks his destiny, only to discover that it is the journey that really matters. Illness can mess up the best-laid life plans and this story provides a timely reminder to us all to enjoy today as well as planning for tomorrow.
7. The Idiot *Fyodor Dostoyevsky.* The principal character in this tale is childlike and yet wise; he also is epileptic. The rejection and isolation he experiences provide a startlingly modern representation of the societal prejudices which patients with epilepsy still encounter.
8. The Spirit Catches You and You Fall Down: a Hmong child, her American doctors, and the collision of two cultures *Anne Fadiman.* Lia is the sixteenth child of Hmong refugees in the USA, whose views on the nature and management of her illness contrast starkly with those of the doctors treating her with disastrous consequences. Outstandingly narrated by a talented novelist-anthropologist.
9. It's Not About the Bike *Lance Armstrong*. An emerging classic by the 26-year-old who recovered from advanced testicular cancer to win the Tour de France in record time. Almost certainly ghost written, this book nevertheless includes some perceptive passages on pulling through, reassessing values, and facing marriage and fatherhood.
10. Never Eat Anything Bigger Than Your Head, and Other Drawings *B Kliban*. Before Larsen, before Glen Baxter, there was Kliban. Dip into this wonderful collection of cartoons to cultivate your sense of the absurd. (A sensible health education message in the title too.....).

Trisha Greenhalgh, Debbie Kirklin, and Brian Glasser

Vermeer and the Delft School
The National Gallery, London
From 22 June 2001

A View of Delft
Anthony Bailey
Chatto & Windus 2001
HB, 288pp, £16.99, 0 70116913 3

Vermeer and Painting in Delft
Axel Ruger
Yale UP, 2001
PB, 72pp, £9.95, 1 85709 910 9

IT is clearly a new trend among exhibition curators to emphasise the pre-eminence of the Great Masters by displaying their work alongside that of their less talented contemporaries. Just as Caravaggio stood out so forcibly from the crowd at the Genius of Rome show, so Vermeer (despite one or two serious misjudgements) leaves his fellows in Delft standing in this latest crowd puller at the National Gallery. Sadly, for all the hype, it is not a great exhibition, and there is little really worth seeing apart from Vermeer s near-contemporary, Carel Fabritius, and a staggering final room of nine of his last works.

The problem with the show is clearly shown by a look at the full exhibition catalogue. The exhibition came on from the Metropolitan Museum, New York, where a much larger number of exhibits were on display, and where the title and the Delft School was rather more justifiable. Here, there is very little art apart from painting, and the choice of artefacts to illustrate other forms of endeavour in 17th century Delft is, frankly, bizarre why choose a number of tiles, crudely painted with church interiors when, as the New York catalogue reveals, you could have been looking at some rather more interesting glass and silverware? And why give so much prominence to Pieter de Hooch? This hugely overrated artist is revealed as a barely incompetent journeyman, whose lifeless scenes are rendered truly strange (and I suppose interesting) by his spectacular inability to paint children, all of whom look like old people painted very small.

Equally undistinguished is Anthony Bailey s absurd book, *A View of Delft*, in which a towering edifice of speculation and fantasy is erected by generating a hypothesis, shortly afterwards representing this hypothesis as fact, and then generating another hypothesis on that basis. My favourite is the idea, based solely on a reference by Vermeer s widow to the artist s decadence and decay in his final days, that he deliberately drank himself to death. Speculation as to his merits as a marksman in the militia company to which he belonged is also rather sweet, and will certainly appeal to many of the six-year-olds for whom this patronising exercise in making the artist come alive was presumably intended. It is a little intimidating that John Updike is quoted on the back cover as greatly admiring the book, but it is actually truly terrible. Even when he s not writing at the level of The Wonder Book of Dutch Painters , do you really want to read, over several pages, about whether or not Vermeer used a camera obscura to construct the outlines of his paintings, let alone whether he used his mother-in-law s wardrobe as a props cupboard?

Much more interesting is Axel Ruger s book, *Vermeer and Painting in Delft*, which is specifically intended to accompany the National Gallery s version of the show. This concentrates on the history of Delft, on the various types of painting popular there, and on three artists in particular, Fabritius, de Hooch, and Vermeer. There is no attempt at meretricious reconstruction , and the works are soberly discussed. Perhaps sensibly, he does not show the spectacularly bad Allegory of the Faith , in which all the feverish symbolism of the Counter Reformation is matched by quite startling incompetence. The central figure s legs, for instance, start just below her waist (did the Holy Office not approve of buttocks?), and the spatial relationships of the various bits of Jesuitical hexerei on the altar beside her are impossible to work out.

This painting apart, this final room is breathtaking, and contains one work, The Art of Painting from the Kunsthistorisches Museum in Vienna, which makes going worthwhile almost on its own. It is, unfortunately, all too likely that your fellow visitors will feel exactly the same. While admittance is limited to 360 people per hour, most of these will, I suspect, quickly find their way to the last room, and the very fact of these paintings greatness will make it impossible for you to see them properly: trapped in a heaving mass of the middle classes at their most unattractive, you will be hard pressed to savour the tranquillity that made Vermeer so popular in the first place.

Frank Minns

Tate Modern: The Turbine Hall

WHAT would be the ideal escape from the emotional swamp we wade through each day in general practice?

I suggest a day in London, a walk by the river and a visit to Tate Modern. If you visited last year (among the thousands of others) you will remember the huge Turbine Hall and the three installations by Louise Bourgeois. The building was originally Bankside Power Station and its architect (Sir George Gilbert Scott) also designed the similarly monumental Anglican Cathedral in Liverpool.

The Turbine Room is one of the few places large enough to construct pieces that alter perceptions and involve the viewer. A new exhibition occupies this area now and I would recommend a visit. Juan Muæoz has constructed a ceiling which can be viewed from below (with half glimpsed bronze figures above) and from the bridge where all we can see is an open area with two lifts in it.

Why is this an escape? Visual arts of this type allow us to experience new perceptions of space and our position in it. The experience is intuitive rather than intellectual and the contrast between this and the paintings in the National Gallery is similar to the difference between a Samuel Beckett play and one by Shakespeare. More importantly, you will enjoy it.

There is no entry charge and late opening on Fridays and Saturdays to 10pm.

Honor Merriman

neville goodman

Latin

I would ve been a judge but I didn t have the Latin; I didn t have the Latin for the judgin ... Latin ceased to be a requirement for reading medicine at Oxford University a year or two before Peter Cook and Dudley Moore s famous sketch, which began with this line. So, a medical student of the 1960s, I don t have the Latin either. I had to learn what medical terms meant rather than being able to work them out, but for the life of me I can t imagine why Latin was deemed essential for so long. Latin is useful in many other ways. It s invaluable before a fortnight in Ibiza, for example; the Berlitz phrase book becomes just that little bit less impenetrable. My attempt to ask a waitress for the bill in a restaurant in Madeira (where they speak Portuguese, another language of Romantic origin) produced only hysterical laughter from the waitress and from her colleague behind the bar, up to whom she rushed to whisper exactly what it was I d said to her. Latin, I am certain, would have saved me much embarrassment.

But in all my time in medicine, I can honestly say that I have never sighed at the vastly superior medical knowledge of a fellow student or doctor whose medical knowledge was superior because they had the Latin. Abandoning Latin meant we had to start writing explicit English on prescriptions, instead of qds and other abbreviations not understood by either doctor or patient. In anatomy, where I guess Latin is most useful, the reason I didn t know anything was that I didn t learn any anatomy. There were no spot checks, and no tests for five terms. I passed anatomy by staying up until 4.00 am on the day of the anatomy viva, reading *Grant's Atlas of Anatomy*. It s a good job I wasn t given a skull, because I d fallen asleep just as I reached that chapter. But I was handed a fibula, and the previous night s reading enabled me to recall the picture of its muscle insertions from the page.

All of which is not quite pertinent, because my real gripe is about Greek. Why do we persist with the prefixes hyper and hypo ? How many patients have come to harm because hyper and hypo have been misheard or mistyped for one another? My very first letter to a medical journal (the *BMJ* in 1972) suggested we anglicise these prefixes to hi and lo . No-one s taken any notice yet. Especially not the local garage advertising hyper-low prices .

Nev.W.Goodman@bris.ac.uk

saul miller

Standardisation

You would have thought that the European Union would have given it all too much of a bad name by now. What with the unravelling of the Common Agricultural Policy, rumours about directives on straight bananas, the gratuitous destruction of our imperial weights and measures heritage, the uncertainty about the Euro, and so on and so forth, you would have thought that no-one would be taking standardisation seriously. Ah well, I hear you say, but the police still insist on officers being above a certain standard in height. True, but that does not mean much, since shorties do get now, after all.

I have a bee in my bonnet because I keep hearing others around me talking about standardisation as though it is intrinsically a good thing. Meanwhile, I am feeling deluged by the quantity of new standards being imposed. I remember it as starting with targets for things like immunisations and attendance at sponsored feasts, but it might have started much further back than that. Certainly, in my short time, things have already progressed from targets to charters to indicators to guidelines, and now to partnerships and frameworks and no coffee till tea-time. Soon comes revalidation and, for some, the hapless, luckless ones, invalidation.

In this heady atmosphere of progress, where resources are still tight and yet the government is throwing money at the NHS, standardisation appears to have become one of those key terms that helps to unlock great reservoirs of money for the right project. Want help getting straight bananas to all those sword-swallowers deficient in potassium? Say standardisation , and no further explanation is needed. It is a Good Thing.

But what exactly is standardisation? It is nothing more than making everything the same in some respect. I am sure that everyone can think of plenty of examples of where this would be viewed as a bad thing: I can. What about standardising all travel, so that it involves only the train? Or all holidays, so that they take in Swindon? Or all GPs, so that they really do wear tweed jackets (even the women)? The truth is, nothing is intrinsically good except goodness, and even that statement could ensnare me in a lifetime of philosophical argument.

Standards are only good insofar as they achieve something positive. The standard that requires all registered doctors to have been through a recognised medical school is positive because it protects patients from charlatans. Well, occasionally anyway. The standard that requires GPs to inform their patients of their surgery phone number is positive because it helps to ensure that patients can contact them sometimes. You get the gist of this, I am sure. Changing tack for a moment, have you noticed how everyone who has been out of general practice for a while and then returns, says it hasn t changed? Doctors who have faced extreme life-altering situations in Borneo and Bromley and Brazil, all seem to find nothing has changed at all when they get back to working as a GP again. Mostly, they don t reveal this with any great surge of despondency but rather with an air of gentle affection for the job they have returned to. But it isn t really the job they feel this way about, it is the patients: not specific individuals, but the unchanging *mélange* of people and their problems.

This, I think, is a strength of our speciality: that the nature of patients problems does not really change that much over time. Or perhaps the real strength is that the nature of the patients does not change. So when I all fired up with newly introduced standards I must apply in my work suggest to someone who comes to me for help that I send him to others who will poke tubes in every available cavity, meanwhile check for three things he was not previously worried about, and prescribe a medicine that is not so good but is cheap, I hope that he will set me right.

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Frank Minns has now left the navy with insufficient fanfare

... Patients as Poets
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