

The Back Pages

viewpoint

The end of single-handed practice?

THE actions of Harold Shipman raise the question about whether society can ever be safe from determined killers, whether medically qualified or not. The fact of Shipman being a medical practitioner has focused attention on the ability of medicine to identify malicious and deviant behaviour among its adherents. However, this specific question is more appropriately replaced by asking whether the paymasters of general practice the public have sufficient assurances of quality in a more general sense.

Frankel *et al* have suggested that the routine monitoring of death certification, as a contributory method of doing this in small GP practice populations, is fraught with difficulties.¹ This reflects our own experience. In a preliminary study we needed much time to make death certification data suitable for electronic analysis. Errors or potential errors made our exercise fraught with difficulty in our service setting. An example of the problems faced included individual practitioners having their addresses represented in several ways. Others include doctors having identical names and difficulties arising from interpretation of data from death certificates signed by training doctors, locums or out-of-hours services. The average number of death certificates signed by practices is small: in Grampian region in 1999, the figure was 28. Statistical methods of coping with small numbers, such as analysing data for periods of several years, means that the method is not responsive to identifying quickly sudden changes in death or death certification in a practice. A different approach might be productive. We should learn from the experience of the paediatric service and construct the equivalent of the Apgar score for the end of life. A numerical rating based on observations on the quality of the death experience from a relative and professional perspective would be more useful than simply counting deaths. Illuminating practice reduces the risk of putrefaction and will create learning.

Pringle argues that we must put in place systems that ensure that the public's confidence [in general practice] is regained ...² He raises the particular difficulties of single-handed practice where the usual difficulties of obtaining confirmation of quality assurance of medical practice are compounded by potential professional isolation. We wonder whether Pringle's confidence in the profession's ability to restore public confidence in single-handed practice is over-optimistic. Given the difficulties of single-handed practice it would not be surprising if the NHS decided, explicitly or implicitly, that it should not make contracts with doctors who wish to practice alone. The burdens faced by solitary individuals are particularly formidable. Difficulties, including illness, which come to every practitioner at some stage of their career, are best addressed in (even suboptimal) partnerships.

Early in the career of one of us (DC), a local general practitioner made a late presentation to hospital with addiction to injected pentazocine. This caused such severe ulceration of her legs with associated anaemia that she needed six months inpatient treatment. The problem had developed unseen and unsuspected, notwithstanding the odour from the ulcers. Such practitioners are more likely to be supported and the public to be protected against suboptimal performance, if they have to work with peers on a daily basis. For these reasons, while single-handed practitioners continue to practice as NHS contractors, the profession should consider requiring them to have a higher burden of proof of their continuing competence and wellbeing. This could include the need to formally respond to health authority commissioned audits of medical care. The RCGP could mediate such audits. Health of single-handed practitioners could also be assessed by periodic review. The NHS occupational health service needs to build up both its understanding of the health challenges of general practice and the resource to undertake this task. Overall, however, the task should be to reduce solitude, encourage team working and, as an intrinsic part of clinical governance, develop an open culture.

Gordon Peterkin
Donald Coid

References

1. Frankel S, Sterne J, Smith, GD. Mortality variations as a measure of general practitioner performance: implications of the Shipman case. *BMJ* 2000; **320**: 489.
2. Pringle, M. The Shipman inquiry: implications for the public's trust in doctors. *Br J Gen Pract* 2000; **50**:355.



“Biology is going to frolic all over this century causing miracles and mayhem as it goes, and medicine will be its dancing partner.”

Paul Hodgkin, reviewing
Kauffman's *Investigations*, page 780

**“... He said,
‘You’ve got
A tumour in there
And a blockage
And it’s cancerous.’”**

Patients as Poets, page 776

contents

770	news Managing poor performance, DIPEX, and domain names
772	miscellany Patents, prices, and public health: Dorothy Logie Commentary — Jeremy Strachan
774	postcards from the 21st century Falling through the net - an addict's perspective Martin Scott
776	poetry Patients as Poets, Part 2 Scott Murray
778	digest and reflection Heath on human rights, Greig on microbiology, Peterkin on paperlessness, Hodgkin on the New Biology, and Tim Albert's books... plus Foot and Mouth in southern Scotland
782	matters arising Whooping it up at AUDGP, and longer training in general practice
783	diary and goodman in Milan
784	our contributors and w illis on numeracy

THERE is much emphasis on making the NHS more patient-centred and sensitive to needs of patients. It is an easy demand to make but far more difficult to fulfill and making it happen remains a major challenge for all of us working in the health services, as well as for patients and their carers. Part of the problem lies in the fact that it is essential to be able to easily access the personal experiences of individual patients who have experienced a wide range of illnesses and treatments.

As health professionals, we are all too aware that to be diagnosed with an illness can be bewildering and frightening, especially if there is no-one around to tell you the things you really want to know. How is this illness going to change my life? How will it affect my relationship with my family, friends, and colleagues? What will the tests involve? How long before I get over the operation? Will I be able to do the things I used to do?

DIPEX (www.dipex.org) is a new internet-based multimedia resource that will answer questions like these by providing access to the personal experiences of others who have faced the same dilemmas.

DIPEX prostate cancer and hypertension modules were very successfully launched in July 2001. There are video clips, the voices and the written accounts of patients relating their experiences of illness and the impact it has had on their lives. The popularity of exchanging personal experiences of illness via the World Wide Web demonstrates the appeal of such narratives.

But all too often, the experiences end up as rent a quote with one or two often sensational or high profile patients. There is also the added difficulty of being unable to check the truth behind many of the details of the patient's story. DIPEX overcomes this problem by including the widest practical range of participants. Invited through GPs, hospital consultants, and support groups, there will be those recently diagnosed with the disease and others who are in the midst of treatment as well as those completely cured. Each site, dealing with a different disease process, involves the experiences of between 40 and 60 patients with experiences both good and bad.

The interviews are recorded on digital video or audio tape and then analysed by the researchers. They are assisted by an Advisory Group for each disease which includes professional and lay experts, representatives from support groups, and clinicians, including GPs. The analysis uses qualitative methods to identify themes that are presented on the site as topic summaries illustrated with video, audio clips, and written excerpts from the interviews. The information sections and answers to questions provide context and any ideas that are factually incorrect are explained.

DISCERN criteria for consumer health information are used to assess the quality of the information

The aim of DIPEX database is to provide a resource of individual patient experiences so as to offer knowledge in a way that allows more balanced encounters to occur between patients and health care professionals. However, DIPEX is not only a resource for patients and their carers but provides much more. It has great potential for educating doctors, medical students, nurses, and other health professionals, and is a means of providing a patient-centred perspective to researchers, managers and those who commission health services by giving access to the patient's real perspective.

The multidisciplinary DIPEX team is based in the Department of Primary Care at the University of Oxford. It is a registered charity with funding from the Department of Health, Macmillan Cancer Relief and the Citrina Foundation. Information on the prostate cancer site is provided by CancerBACUP.

All in all, DIPEX promises to be the single most up-to-date and influential tool available to patients and doctors alike in achieving the goal of making medicine - medical decision making, medical experiences, and the evidence on which medical decisions are made - more available to all those most directly concerned, and most importantly the patients themselves.

It is important that this resource is not denied to groups and individuals without Internet connections. Therefore it is planned that DIPEX will also be available on CD ROM in outpatient departments, through support groups, GPs surgeries, public libraries, medical schools, and information centres.

A DIPEX GP network is currently being set up. We are seeking individual GPs and practices who are willing to identify participants for future DIPEX modules to be part of advisory panels and/or help evaluate DIPEX with patients, medical students and GP registrars as a teaching resource. Breast cancer is nearly complete and we will be recruiting patients with cancer of the testes, bowel, and cervix as well as women who have had an abnormal smear. We will be recruiting patients with cancers (including ovarian, lung, and oesophageal cancer), epilepsy, motor neurone disease, cardiac failure, and teenagers with cancer or leukaemia.

If you would like to be involved in the DIPEX GP network or have patients who you could approach to take part, please contact DIPEX 01865 226672 or dipex@dphpc.ox.ac.uk

Managing poor performance

As part of its activity to support clinical governance leads, the St Paul RCGP Quality Unit is coordinating the development of a toolkit for the management of poor performance in general practice and organising a series of conferences with the National Primary Care R&D Centre in Manchester, and the Clinical Governance R&D Unit in Leicester. The most recent conference was held on 3 July in Manchester and covered issues around managing poor performance in primary care. Speakers included those involved in actual performance panels at health authorities, the General Medical Council, postgraduate education, the Department of Health, and the National Clinical Assessment Authority. Delegates included managers and doctors working with poor performance issues at local, district, and regional level.

Important themes emerging from this event

The role of the NCAA

As purely an assessment body it was felt that the NCAA is perhaps avoiding the more complex issue of making a difference and certainly is not going to be providing resources to actually help doctors with problems. It was unclear what they might add if the assessment process is completed successfully at a local level, although commissioning a nationally approved method of assessment would be helpful.

Legal and ethical issues

Issues around consent, human rights, data protection, and discrimination are changing constantly. It was unclear, for instance:

What level of consent is required to access a patient's notes? Government action is anticipated.

How will the conflicting problems of protecting whistleblowers and allowing doctors access to all the information about them be resolved? Basically, anonymous information cannot be used.

How will managing poor performance avoid the legal pitfalls without being too cumbersome? Determination, fairness, and careful documentation will be required.

To screen or not to screen?

Two speakers talked of differing experiences in respect of using a screening tool to suggest possible poor performance, or solely responding to concerns. It is likely

that screening is fairer, but work is needed to get the right screening tools developed.

How to actually make an improvement

Although GP postgraduate departments have made great inroads in helping poorly performing doctors, it was emphasised that this is a long and resource-hungry process. Mentors appear to be a valuable part of this process. Education and training are only part of the improvement process, input to practice organisation, management and clinical support, (e.g. through parachute doctors and practice nurses), are equally important.

Delegates also noted that the RCGP Quality Team Development programme was a useful tool in identifying poor performance, as its ethos concentrates on the ongoing development and education of general practice.

Appraisals

David Colin-Thomø highlighted the early thinking about appraisals for GPs. As a formative, confidential and, most importantly, constructive process, it must not be seen as a method to root out poor performers, or credibility will soon be lost. However, where an appraiser detects that the doctor is performing badly, inevitable problems will occur unless the doctor can be persuaded to self-refer to the local performance group.

The GMC methodology for performance assessment is very illuminating. This is clearly a robust, thorough and, above all else, fair process, often commended by the doctors actually going through it. Although local performance procedures are unlikely to be in the position to replicate the detail of the GMC, there is much to be learned from their assessment process.

More details about the conference are available on the NPCRDC website (www.npcrdc.man.ac.uk).

The toolkit was seen in final draft form. It will be launched formally in September, although we expect, with the world constantly changing, for it to evolve. Keep a look out on our website. www.rcgp.org.uk/rcgp/quality_unit/index.asp.

**Tim Wilson
Fiona Smith**

The Internet domain name system

JUST as postcodes are used for houses and businesses, every computer connected to any network has to have an address so that electronic information is delivered to the right place. When the World Wide Web began in the mid-1990s, it initially used a numerical system that had been developed for smaller networks, the Internet protocol (IP) address. These are in the form of four-figure groups with a permissible range of 0 to 255 in each group. For example, the address of the computer on my home network is 198.68.1.2, and the IP address of the RCGP server is 195.224.175.6. The numbers are useful, but difficult to remember, so it was decided that there would be a system that converted these numerical addresses into more user-friendly names.

The resulting names are easier to recall and help people to find information on the Internet. Domain names form part of website addresses (technically known as URLs Uniform Resource Locators) and they are also used in e-mail addresses that enable people to send and receive electronic messages. As well as the company or organisation name there was initially a three-letter suffix. This was to denote a commercial, military, educational, or governmental organisation, or a non-profit making entity. Companies connected with the provision of Internet services, such as hosting, would have their own suffix. Thus the first domains had .com, .mil, .edu, .gov, .org or .net at the end of their addresses.

It rapidly became clear that a suffix denoting the country of origin would be useful and every country now has a two-letter suffix (see <http://www.iana.org/cctld/cctld-whois.htm> for the list). The usual abbreviations, such as gov, mil, org, and net as described above were used, but .com became .co (plus .ltd or .plc or the equivalent in other languages) and .edu became .ac standing for academic, with the country code after it. Thus Sheffield University has the address www.sheffield.ac.uk

Since the explosion of the Web there has been a problem with companies with similar names wanting to have control over the Internet address that is most suitable or memorable. One of the best examples of a way of resolving such disputes concerned a New York law firm and a small steel-making company in the United States. Both have the same initials and the steel company had registered the domain first. After a short legal tussle, the New York law firm bought the steel company in its entirety and renamed it in order to have access to the domain!

In my next column I will talk about the organisational aspects of the system, why the NHS is unique in having its own domain (.nhs.uk) and the new top-level domains that became available this summer.

ZYBAN is only one new drug that threatens to unbalance our drug budgets. Keeping the lid on prescribing costs is increasingly difficult. As well as lifestyle drugs, a whole new generation of costly genetics-based pharmaceuticals waits in the wings. Who controls their price? In the past few years an international agreement that will make future drugs more expensive crept onto the statute books. While we were busy setting up Primary Care Trusts, the World Trade Organisation (WTO) quietly altered the intellectual property laws, or monopoly privileges, in a way which could affect NHS costs, as well as denying cheap drugs to poor countries.¹

TRIPs

Under the grand name of Trade-Related Intellectual Property Rights (TRIPs) the United States, Europe, and Japan drove the 1995 WTO agreement onto the statute books.² It is no co-incidence that northern companies own 90% of global patents on pharmaceutical products and they want to protect them. The TRIPs agreement (now law in most countries) has beefed up intellectual property rights, not only for drugs but also for seed patents, biogenetic processes, and computer programmes even scientific knowledge.³ Rich countries as well as poor are worried about the cost of the patent extension on drug prices and both are concerned about the patenting of plants, animals, and genes, fearing increased biopiracy.

What the TRIPs agreement says⁴

- It commits governments to enforce drug patents (for both the drug and the manufacturing process)
- It extends patents to 20 years
- Countries have to alter their national legislation and comply or face trade sanctions
- All countries must offer 'market exclusivity' to drugs for which patents were filed after 1995.

The TRIPs agreement is complex and the US employs an army of lawyers to oversee claims. In brief, it extends the length of drug patents (to 20 years) while also expanding the scope of patents to include various stages of the manufacturing process. Many countries that manufacture generics, such as India, Thailand, and Brazil, previously excluded drugs from their patent laws.⁵ Now they have to obey WTO rules or feel the big stick of American trade sanctions.

What about public health?

Poor countries depend on new drugs to treat resistant forms of disease and new diseases such as HIV/AIDS. Do public health concerns feature in the new rules on patents and pricing? The answer is no. The TRIPs agreement is all about protecting trade, monopolies, and stock market prices, not about making cheap drugs accessible to the poor. The rationale given for beefing up

intellectual property rights is to stimulate drug innovation, guarantee inward investment for pharmaceutical companies, and ensure R&D for new drugs. For one-third of the world's population (two billion people) this rings hollow. They do not have access to essential medicines, and innovation of new drugs to cure their most common diseases is practically zero. Only 0.2% of health-related research goes to drugs for TB, pneumonia or diarrhoea, illnesses that account for 18% of global mortality.⁶ In addition, some drug research is done in academic settings, funded by taxpayers money. So the \$500 million cost quoted by the drug companies to put a new drug on the market includes huge marketing costs, and profits.⁷

Safeguards within the TRIPs agreement

There are two get-out clauses: Article 31 of TRIPs allows a government, at times of national crisis, to override the patent and produce a cheap generic copy of a medicine on payment of adequate remuneration to the patent holder. The government then issues a compulsory licence for that drug, for a limited time.⁸ Cheap generics can also be imported into other countries, provided laws are written into national legislation. This is called parallel importing, is widely used and accounts for 12% of NHS prescriptions into the UK.⁹ However, both of these get-out clauses are complex and are a lawyer's paradise: poor countries cannot afford to play the expensive legal game. The US dislikes parallel importing and would like to see it stopped. The South African government, with 4.7 million people infected with HIV, thought that it was dealing with a national crisis when it tried to import cheap generic drugs from Brazil and India. Thirty-nine powerful drug firms, backed by the US government, disagreed and threatened South Africa with trade sanctions.

South Africa

It was the mega-scandal of the century, the tale of how a \$350 billion dollar pharmaceutical industry held millions of poor people to ransom for three years by refusing them access to life-saving drugs in the midst of a major epidemic.¹⁰ It wasn't just anti-retrovirals but new drugs for meningitis and new antibiotics. Outraged public opinion led to the case collapsing in April this year. There was no final judgement and fears persist that America could weigh in once more against some poor country deemed to be manipulating WTO rules. The South African case was not only about the use of anti-AIDS drugs, nor about the narrow technical provision to reduce the price of medicines it was about the rights of a government to place the health of its people over vested corporate interests.

Cheaper drugs for Africa

Over the past year, in response to public pressure and the growing AIDS epidemic, several firms have either donated patented drugs or cut their prices under the UN-led Accelerated Access scheme.

References

1. Correa C. *Intellectual property rights and the use of compulsory licenses: options for developing countries*. The South Centre; working paper. October 1999.
2. Drahos P. *Global property rights in information: the story of TRIPs at the GATT*. *Prometheus* June 1995; 13: (1).
3. Wemos and Medact. *World Trade Organisation: implications for health policy*. [European Health Alliance and Medact Briefing Paper.] London, 2000; 8.
4. World Trade Organisation. *TRIPs and pharmaceutical patents*. WTO fact sheet, 2001. Available at: http://www.wto.org/english/tratop_e/trips_e/trips_e.htm.
5. Oxfam. *Patent injustice: how world trade rules threaten the health of poor people*. Oxfam Publications. Oxford 2001; 6.
6. VSO. *Drug deals: medicine, development and HIV/AIDS. A VSO Position paper*. London: VSO, 2000.
7. Oxfam. *Dare to lead: public health and company wealth*. [Oxfam briefing paper on GlaxoSmithKline.] London: Oxfam, 2000.
8. Medicins Sans Frontiers. *Access to essential Medicines*. [MSF Briefing paper.] June 2000.
9. Rowson M. *Patents, prices and pharmaceuticals: implications for EU and US customers*. [Medact briefing paper.] London: April 2001.
10. South Africa's moral victory. [Leader.] *Lancet* 2001; 357: 1303.
11. South Centre. *Patents, TRIPs and public health*. *South Bulletin*; 9 March 2001.
12. Clark A. *Glaxo relents on Aids drugs*. *The Guardian*; 22 February 2001.
13. Oxfam. *Patent injustice: how world trade rules threaten the health of poor people*. Oxford: Oxfam Publications, 2001; 7.
14. WHO. *Globalisation, TRIPs and access to pharmaceuticals*. *WHO Policy Perspectives on Medicines*. [No 3.] Geneva: WHO, March 2001.
15. WHO. *Increasing and sustaining access to Essential Medicines*. *Drug Policy at the 54th World Health Assembly*. May 2001. *A background briefing paper*. Netherlands: Health Action International, 2001.

GlaxoSmithKline, for example, has offered Combivir (a combination of AZT and 3TC) for \$2 a day, instead of the previous \$16.¹² This price is still beyond the pockets of most Africans who have to fund their own health care and whose average monthly income is \$50. Pharmaceutical companies cite these initiatives as socially responsive marketing.¹³ But goodwill gestures, which depend on islands of philanthropy, distract from attempts to remedy the flaws in the TRIPS agreement. And drug companies still strive to protect their patents and block parallel importing of generics.¹⁴

The effect of TRIPS on poor countries

- It affects prices of drugs patented after 1995
- The full impact has not yet been felt as only 5% of essential drugs are under patent
- It will affect new drugs, e.g. for resistant malaria, TB, pneumonia, meningitis, and shigella¹¹
- It will be illegal to produce low-cost generic copies of drugs for at least 20 years from the date of patent filing

The way forward

Cheaper drugs for poor countries are not the answer to the health crisis in the south: these countries need decent health services, adequate infrastructure, improved remuneration for health staff, and so on. But cutting the costs of medicines and shifting the balance of patent laws in favour of the poor and of public health would be a start.

There is a definite role for the medical profession to pursue. Backed by WHO, we must insist on openness and detailed information about drug pricing, provide model laws on compulsory licensing for countries that do not have the legal expertise, ensure quality generic drugs are available, and encourage R&D for diseases of poor countries.¹⁵ But above all, doctors and governments must be allowed to override patents when public health is threatened.

Dorothy Logie

The generic drug industry

- India, Brazil, Thailand, Egypt all have a thriving generic drug industry.
- By introducing free anti-HIV therapy, Brazil has halved its HIV rates
- Indian companies, such as CIPLA are discussing with 10 African countries the sale of antiretroviral cocktail at one-tenth of the current price
- Thailand can make the triple anti-AIDS drug cocktail for 60 cents per day.

Commentary

IF international patent protection for medicines under TRIPS amounts to the globalisation of an iniquity, why have over 140 countries, with apparent willingness, signed up to it?

Part of the answer lies in the underlying rationale for TRIPS which, incidentally, did not invent 20-year patents for pharmaceuticals. TRIPS is a harmonisation measure. Because patent law is national, different countries had adopted varying lengths of patent life and did not agree on what inventions could or could not be patented. Some developing countries, such as Pakistan, had patent protection for drugs; others, such as India, effectively excluded drugs from their patent regime. Implementation arrangements for TRIPS take account of the fact that many developed countries were already in compliance with the new standards while others would need time to put in place the necessary changes.

TRIPS has nothing to do with prices. Patents are state-conferred temporary monopolies which give their owner the right to stop others from making or using the patented product; they do not give the owner the right to charge whatever price he chooses. Indeed, most developed countries, with the significant exception of the United States but including the United Kingdom, either directly or indirectly control pharmaceutical prices notwithstanding that the drug concerned is patented and can't therefore be copied or marketed by anyone else.

Most observers agree that patents act as a vital catalyst and incentive to innovation. Many drugs are easy and cheap to copy and the Western companies, which are the only source of new and effective drugs, will simply not make the huge and risky investments involved in discovering and developing new ones if they are not protected from direct competition for a period necessary to recoup and profit from their investment.

TRIPs is not a perfect instrument; few complex treaties signed up to by most of the world community ever give all adherents all that they want. However it does contain within it an under-appreciated degree of flexibility — the boundaries of which are still being constructively explored by WTO members — designed to balance the importance of encouraging and rewarding innovation with the pursuit of public health objectives. If we accept this delicate balancing act as a more measured expression of the rather vague plea that doctors and governments must be allowed to override patents when public health is threatened, then few on the other side of this decreasingly acrimonious debate would disagree.

Jeremy Strachan

This is the seventh 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

Falling through the net an addict's perspective

I VE been a registered addict for 15 years but the roots of my addiction go as far back as the early 1970s when, while in care, I first experimented with solvents in a desperate attempt to escape the harsh realities of institutional life. It was recognised that I had above average intelligence but, although I expressed an interest in education, it was neither encouraged nor provided while in care.

At the age of 16, unable to adjust to civilian life, I joined the Royal Navy and fell prey to an entrenched drink culture. I progressed from solvents to binge drinking and amphetamine abuse. After numerous brushes with the brass I was eventually incarcerated in a military facility which, although it professed rehabilitation, proved to be a punitive regime. Dishonorably discharged, I drifted, alternating bouts of heavy drinking and casual drug abuse with more positive attempts to forge a future for myself by enrolling on various academic courses and pursuing an interest in the theatre: a pattern that circumscribed my adult life for the next 15 years. Although I came into contact with numerous professional bodies during this period (usually probation services for limited periods of a few months as dictated by the courts) no effective programme of help was forthcoming.

Throughout the 1980s I continued with my binge drinking and casual drug use, progressing from amphetamines to heroin and other opiates. In 1989, after years of denial, two broken marriages, a brain haemorrhage, numerous sackings, the odd spell in prison and a plethora of temporary homes, I finally sought professional help from a local drug project, and was referred to a local surgery sympathetic to drug abusers. I was immediately placed on an oral methadone maintenance programme. Unfortunately, the regime failed to stop me injecting black market drugs. Desperate, my GP changed my prescription from 60 ml oral to 100 ml, and then to 150 ml of injectable methadone. The problem with methadone is that it has none of the qualities an addict looks for in a drug while manifesting all of the drawbacks. It is non-euphoric, yet it's infinitely more addictive and harder to kick than heroin. Many registered addicts consequently supplement their methadone scripts with cyclazine, among other drugs. Easily obtainable and perfectly legal to possess, cyclazine provides the intense rush of euphoria methadone is unable to deliver, but which

every addict craves. In my experience it's the most psychologically damaging, psychosis-inducing, and potentially lethal drug I've ever come across. One becomes easily tolerant of it so it has to be taken in increasingly larger doses. At the height of my dependency I was using approximately eight 50 g tablets per hit, putting an enormous strain on my heart and circulatory system and responsible for numerous bouts of deep vein thrombosis, clogged arteries, and abscesses.

Of all the GPs that have addressed my drug problem, only one recognised that success depended on a co-ordinated effort from GPs and the relevant services to address the social and domestic problems that had so far prevented me from establishing the stable base essential for recovery. He managed to organise one session with the express purpose of finding me suitable and permanent accommodation before he was forced into early retirement and the initiative was shelved. The meeting which I attended was a model of constructive and positive debate but, in practical terms, it achieved little. I was dumped in a 14th floor high-rise flat on a housing estate notorious for its entrenched drug problem, despite my disability and despite the common consensus that to place a recovering addict in such an environment was counter-productive. As a result of this experience I became quite cynical and contemptuous of local government bodies who, in my experience, pay little more than lip service to the problems of addicts.

Desperate and demoralised I volunteered for supervised detox and rehab. Unfortunately, my experience with rehab turned out to be an even more demoralising experience, lasting a mere three weeks and resulting in my immediate return to the drug scene. In my experience, drug treatment agencies have to act quickly and decisively when an addict volunteers for such treatment. They must get it right the first time for, in the majority of cases, if the detox element is not adequately paced, or the rehab regime not suited to the particular addict, then addicts will continue to fall through the net, as I did. I had no effective counselling, instead, I was thrown a bunch of leaflets and nonchalantly asked to take my pick. I was kept hanging around for months (still expected to maintain my commitment) until one of the two beds available for addicts in the Sheffield area became vacant, only to be placed in a general psychiatric ward, among disturbed

and disruptive patients; a totally unsuitable environment for detox. I was unrealistically expected to be completely detoxicated within seven days, reducing my dose from 150 ml a day to zero; impossible with a drug with such a notoriously long half-life as methadone. I was then expected to cope with the emotional and physical pressures of rehab while still suffering from withdrawal symptoms.

Despite this negative experience, I plucked up enough courage to try again. This time I researched my options thoroughly, again without significant support from relevant agencies, and eventually chose a clinic that seemed to offer the best chance of success. I was interviewed and accepted for the first available bed. I spent months preparing myself, addressing my fears and trying to reduce my habit, only to be informed the day I was due to leave that the rehab unit in question had been closed for repairs indefinitely. My counsellor on that occasion had been in receipt of this information for some time, but had gone on leave and forgot to mention it to me on his return. I was devastated, and never again even considered such a course.

The turning point in the struggle with my addiction came after I collapsed in the street and was diagnosed with a tumour on my right hip muscle (caused by a virus with symptoms not dissimilar to osteoporosis), which had damaged a significant portion of my hip bone, methicillin-resistant *Staphylococcus aureus*, and other complications. Laying in intensive care, hooked up to various machines, breathing through an oxygen mask with only a 50/50% chance of surviving the ordeal, wracked with guilt whenever I opened my eyes and witnessed my family's grief, I made a deal with myself. If I survived this latest ordeal I would endeavour to end my addiction. After several months in hospital I was released, partially and permanently disabled, but determined to prevail.

Over the course of the past four to five years I've transformed myself from a hopeless addict, playing Russian roulette with my life, to become a more settled, positive, and productive member of society. The first crucial step was to combat my addiction to methadone and cyclazine. This was achieved by prescribing a daily regime of diamorphine, which forced me into a more disciplined management of my script, and indirectly a more disciplined

lifestyle. I'm in the third year of a part-time English degree having successfully completed a two-year access course and have re-established an interest in creative writing. I have severed all links with the drug-using community, reformed links with members of my family (though unfortunately not with my children) and made new friends, not connected with the scene. These successes are due in no small measure to the financial and domestic security which, after years of drifting, living hand to mouth, day to day, fix to fix, the state has finally granted me. At last I live in a decent home, in a non-drug-using community. Because of my disability I now draw a decent income which gives me sufficient funds to free myself from the soul-destroying, seemingly endless cycle of being in debt and unable to plan beyond the next day; with all one's energies devoted just to keeping one's head above the poverty line, until eventually one can bear it no longer and seeks escape, some relief, however transient and ultimately self-defeating it may prove to be. I hope to use my newfound security as a springboard to the fully independent existence I've craved all my life.

I can offer no definitive solutions to what is a complex social problem. However, a genuine commitment to redressing the stereotypes and negative attitudes that addicts daily have to contend with might be a good place to start. Heroin is known to suppress emotion and consequently addicts often come across as selfish, cold, and manipulative operators who seem to express contempt for anyone endeavouring to help them. As a consequence of this, many GPs coming into contact with addicts for the first time soon find their patience and commitment tested to the limit. Instead of criminalising the addict, drug addiction ought to be recognised as an illness.

The drug problem is a spiralling social problem affecting us all and exacerbated by a series of social inequalities; bad housing, rundown communities, unemployment, inadequate benefits, and a marked lack of resources to deal with these problems. The municipal indifference to the plight of generations of predominantly working class kids needs to be addressed now if society is seriously committed to rehabilitating addicts, rather than punishing them and condemning them and society to a bleak future. *Quid pro quo.*

Martin Scott

Illegal drugs - the big picture

WORLDWIDE, illegal drugs sales probably account for \$150 billion per year. The comparable figure for tobacco is \$200 billion, and for alcohol \$250 billion. Legitimate sales by the worldwide pharmaceutical industry were \$300 billion. Drug prices in most developed countries have fallen in the last decade, while purity has risen: in 1980 one gram of pure heroin cost \$5000 in the US. Today it costs \$1000.

The most addictive drugs are nicotine and heroin. Many other drugs are less addictive than we think: one study of cocaine users showed that, at 10-year follow-up 60% were completely abstinent while almost all the rest were only occasional users.

Alcohol has been estimated to be responsible for 3.5% of the disability-adjusted life years worldwide, tobacco for 2.6%, and illicit drugs for 0.6% (1990 figures).

Control of supply occasionally works in one country (usually at great expense to civil liberties) but usually results in shifting production elsewhere. Profit margins on drugs make many kinds of control impossible. Typically, 1 kg of cocaine has a US retail value of \$110 000. Buying a new plane for each run merely adds \$2000 to the street price of each kilo — equal to a few cents per hit. Educational strategies to reduce demand have had little effect on consumption. The major proven result of 'War on drugs' strategies is to increase the prison population — especially of young blacks.

Would decriminalisation (legalised possession) or legalisation (legalised trading) help? The one certain effect of legalising drugs would be to lower the price. This would reduce crime and result in more users. The numbers of people with drug-related problems would rise but the intensity of their problems might fall. Overall, the effects would be a 'clear redistribution of harms' — the poor would still use drugs disproportionately (as they do alcohol and tobacco) but the young poor, and especially those from ethnic minorities, would cease to go to prison in such excessive numbers. By contrast, more middle class families would find a drug problem in their midst.

References

1. Cairncross F. High Time: a survey of illegal drugs. *The Economist*; July 28th 2001.
2. Murray CJ, Lopez AD. Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study *Lancet* 1997; **349**: 1436-1442.

I knew...

'I Knew...'

This poem is taken from an interview conducted by our palliative care researcher, as part of a larger, qualitative study in which 20 people, recently diagnosed as having inoperable lung cancer, spoke of their experiences.

When talking about the diagnosis itself, most people gave their accounts in the form of extended stories. As we listened to the interview tapes, we realised that transcribing some sections as poetry might allow readers to more accurately understand the content, and experience the emotions present. These patients were telling their own, unfolding narratives, set vividly in the present time. By extracting these stories and transcribing them into poetry, a window opened into the patient's perspective, and the communication of their emotions and feelings became more immediate.

Last month in the BJGP we explained our research practice in more detail and presented a short poem. This second poem is from a 55-year-old man, whom we invited to read the transcript. He was delighted with the poem, considering it to be an accurate reflection of his experiences and feelings at that time, and is pleased that it is to be published and can be of use to others.

We feel that many professional groups could use the poem. For GPs it highlights various issues: using time as a diagnostic 'tool' (as we teach medical students); patients being alerted to bad news by the radiographer; patients not knowing what questions to ask; the difficulties posed for patients by the delay in starting treatment; patients' needs for information and support at this stage; and given the 'double whammy' of being given a diagnosis of cancer while being robbed of a cure, and the principles to be followed in breaking bad news.

We wonder if presenting patient experiences in this way may prove useful in allowing the patient perspective to be better understood and appreciated by doctors, medical students, and health planners?

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

The first symptom was
I broke my finger at work
And I went to the doctor
.....

And I kept going to the doctor
Saying to him
'You have to give me something, doctor,
Because I'm being awful sick.'

But he was blaming my finger
And saying I was depressed.
I wasn't depressed,
I know I wasn't depressed,

So eventually
I went to him again
And I said,
'You'll have to give me something,
Because I'm losing weight,
I've lost a lot of weight.'

Now we were getting ready
To go on our holidays
And I'm losing weight,
Losing weight
Losing weight.
I was 15 stones
And I went down to 12.
And that was in two months.

And that's when I knew
There was something wrong with me.

I went off my food.
I hardly ate at all,
Next to nothing
I was eating,

So it was back to the doctor,
Before I went on holiday,
And I said to him,
'You'll have to give me some
Antibiotics.'

'Antibiotics
Will not help you,'
He said.
He said,
'It's your finger.'

I told him
I was spitting blood up,
And all that,
And still,
He wouldn't give me
Any treatment.

So we went away
On holiday,
And everything
Was free there,
Including the food,

But I had this thing,
That I would go for dinner,
At night,
Then I would go for breakfast

And all that would come
Back up again.
And I knew
There was something wrong.

Plus,
I was spitting
A touch of blood,
Now and again,
And that
Was worrying.
I said,
'There is something wrong,
Within myself.'

And that's
What I thought I'd got,
But you're not wanting
To believe it,
You know?
.....

So they gave me a line,
There and then
That day,
And I went for
The chest x-ray.

And I knew

Straightaway,
By the girl,
When she said to me,
'Just get ready,
And we'll contact you,
As soon as we can.'

I thought,
'There's something.
They've got something.'

But she wouldn't
tell me.
I said,
'Come on,
Tell me.
What's on that x-ray?'

She said,
'I'm sorry,
I can't.
You'll get an appointment
With your own
GP.'
.....

So they sent me back
Into the clinic
And the chap there said,
He said,
'You've got a shadow,
On the lung.'
He said,
'Until we find out
What it is,
We can't say if
It's cancerous,
Or not.'

He said.

But,
At the back of my mind,
I thought,
'That's what it is.'
I knew.

So I was taken,
Into hospital again, for a bronchoscopy,
Or something that they call it,
I can't remember
The word.
They took me
Down to the theatre
And gave me that.
.....

And they put
The camera on,
And I could have seen it,
If I'd asked.

So they took
A wee swab,
Just to examine,
What it was,
Because they still
Couldn't tell me.

But they could
Tell me
It was a blockage,
And there was a growth.
They could tell me
That was what he'd seen.
But they still,
Couldn't tell me
If it was cancerous.

So we made an appointment
To go up again
The next week,
And that's when he told me,
The bad news.

He said,
'Well,'
He said,
'I'm not going
To beat behind the bush,'
He said,
'You've got
A tumour in there
And a blockage
And it's cancerous.'

He didn't mess.
He just told us,
There and then.

And it was better,
To find out.
At the back
Of my mind
I'd thought
This was what it was.

I knew.
He sat down
And he was very good.
'Have you got
Any questions?'
And I said,
'Well, you've just answered
The first one,
So you're asking me
A question
And you're answering it
At the same time.'

So I didn't really know
That much
To ask him.
Just what sort of symptoms
I would have
And how long until
I would get onto
Treatment.

What an awful pressure
It was.
I couldn't walk anywhere.
I couldn't handle it.

I couldn't do anything
In the house.
I couldn't even
Wash a cup.
That's how bad it was,
Because that's not me.
I just flung it
In the sink
And came back in.
I couldn't handle it
At all.
And that's
Not me.

But he said,
'Once you get onto treatment
You'll feel
A lot better.'
But I still didn't get anything
For weeks.
I couldn't believe it.

I said,
'Are they just kidding me
That they're going to
Put me onto treatment?
Or are they not?'

Because I was going
To the clinic
Almost every week.
And I'd go in there
And he would say again
That they wanted
An operation.

That's what
They did think about,
Operate,
And cut it out.

.....

He said,
'If you leave it
With me
I'll get in touch
With the surgeons,'
And they had a meeting
That Friday.

They all got together
That Friday afternoon.
And then he said,
'We'll get you
To the hospital
For a new
Chemotherapy treatment.
Now it's a fast one
That goes straight into the cell
Right away.'

But when I went
He said,
'No.'
And when he phoned
About the operation
He said,
'No.'

'The surgeons
Are not going
To operate.
They've had a look
At your scan,'
He said,
'And it's too near
All the lymph glands
And all like that,
The arteries.'
He said.
It was too dangerous.
I was
Disappointed.
I think that
Was more disappointing
Than getting told
I had cancer,
Because that
Was my cure.
To cut it out
And then it was
Away.

But up 'til then
I just had to
Accept it.
What could you do?
The man's just
Doing his job.
You can't say
Go ahead and do it.
If he says,
'No,
I'll kill you
If I do that sort of thing.'

So what can you do?

in brief...

Well, Dear Reader, let's talk General Biology! Or should I say, Dear Autonomous Agent or, more formally, Dear Self-Reproducing Molecular System Carrying Out One or More Thermodynamic Work Cycles, for these are thrilling times in biology: typified by a trio of books

Investigations, by Stuart Kauffman, reviewed by Paul Hodgkin overleaf. Here resides difficult, but mind-expanding science, as new biology grapples with the gaps between statistical Newtonian physics, the hazy brilliance of quantum theory, and application to the chaotic, complex world of biospheres in which we live and practise.

Upwind lies **The Doctrine of DNA**, by RW Lewontin (Penguin, 0 1410-0035 X), poacher-turned-gamekeeper, a leading geneticist who is nevertheless unfashionably Marxist and profoundly distrustful of biological determinism. Genes, in making possible the development of human consciousness, have surrendered their power both to determine the individual and its environment. Discuss.

And do such issues saturate contemporary fiction, all over the latest Booker shortlist? Er, No. But in France Michel Houellebecq's **Atomised** (Vintage, 0 09928336 0) dominates the sales charts. An excellent, pacy novel, although it is unconvincing towards the end; however, it is still worth the effort, and wrestling with big existentialist things beyond the ken of polite Anglo-Saxons. Strongly recommended.

Two other must do's for September: read **A Voyage for Madmen** (Profile, 1 86197236 9), on sailing around the world single-handed a tragedy; and visit Rotterdam (only 45 minutes by train from Schiphol) for the greatest ever exhibition of paintings by **Hieronymus Bosch** (Boijmans Van Beuningen Museum, Rotterdam, September 1 11 November).

Alec Logan

The medical profession and human rights: a handbook for a changing agenda

British Medical Association
Zed Books and the BMA, 2001.
PB, 562pp, £18.95, 1 85649612 0

MOST of us have the good fortune never to be faced with the most serious moral dilemmas. We are not asked or pressured to collude in deliberate abuse or torture. Also, unlike some of our colleagues, most of us do not live in fear of being tortured ourselves if we resist state interference in our work. Nonetheless, we are all implicated in the routine and systematic abuse of human rights. The central contention of this magnificent book is that both health and human rights are threatened whenever individual human dignity is compromised. The traditions of medical ethics and the discourse of human rights are essentially complementary; the former protecting human dignity through the imperatives of benevolence, autonomy, and confidentiality; the latter through the articulation of what each citizen has a right to claim from the state. Seen in this light, every dilemma of medical ethics should alert us to the possibility of a violation of human rights. How many ordinary GPs have witnessed the slightly rough handling of a frail older person in a residential institution and done nothing about it? Such incidents are always troubling but can seem slight in the face of many conflicting demands. This book shows very clearly that, as we turn away, we position ourselves right at the top of a very slippery slope. Once the doctor has taken the first few steps towards collaboration, the way back is extremely difficult.

Doctors working exclusively in closed institutions, such as prisons or detention centres, are proportionately more vulnerable to the perils of collusion, isolated from their peers, and much more reliant on the support of those staff who, in positions of power and relative impunity, are the most likely perpetrators of abuse.

States and their politicians look to doctors to implement policy; the hurt, the vulnerable and the marginalised look to doctors for protection. The conflict is deep and intractable but both medical ethics and

human rights dictate that whenever the needs of the patient conflict with those of the state, the doctor should take the part of the patient. Sadly, the ugly history of the 20th century shows very clearly that this does not always happen. Research in Chile, Uruguay, and Argentina demonstrated that the attitudes of doctors to the human rights abuses that occurred under the military dictatorships of the 1970s and 1980s were predicated, not on any universal acceptance of the fundamental tenets of medical ethics, but on the doctors' political allegiances. Whenever a doctor begins to believe that ends justify means, and that the person in front of them is in some way an enemy and thereby fundamentally unworthy, then human rights are threatened. To varying degrees, this same sense of them and us has sanctioned the abuse of people of other races, civilians in time of war, asylum seekers and refugees, women, frail and demented older people, the mentally ill, and prisoners, both political and criminal. Yet, over the last half-century, the United Nations and many international medical organisations have agreed on clear statements of the ethical responsibilities of doctors. In 1975, the World Medical Association published its *Declaration of Tokyo*, which was the first international statement specifically prohibiting medical participation in torture and other cruel, inhuman, or degrading procedures. This prohibition stands whatever the offence of which the victim is suspected, accused or guilty, and the declaration goes on to assert that a doctor's fundamental role is to alleviate distress and that no motive, whether personal, collective or political, shall prevail against this higher purpose. The problem is that such declarations will never help to bolster the resolve of doctors if they are not known or read and, to my shame, I had never heard of the Declaration of Tokyo until I read this book.

Even the most morally robust doctor is faced with difficulties when called to see a patient whose human rights have been violated and this book never falls into the trap of trying to offer simple and formulaic solutions to fraught and complicated situations. Survivors of abuse, of all kinds and in all settings, often refuse to allow their experience to be disclosed for reasons which include personal humiliation and fear of reprisals. Many ordinary GPs will

recognise this predicament from their experience of patients enduring domestic violence. Nonetheless, the doctor retains a responsibility to listen and to see clearly, not to look away and to make careful and accurate records of what is seen. In some circumstances it can be very dangerous for either the patient or the doctor to make those records explicit and official, but an attempt should always be made to make alternative records which offer the possibility of accurate testimony and redress in the future.

Doctors have privileged access to those who are damaged, either through neglect and apathy or more actively and deliberately, by the ways in which society is organised. Whenever a section of the population is deprived of the means of achieving health, through imprisonment, social exclusion or civil conflict, and whenever state decisions have an adverse impact on health, doctors have a duty of advocacy and a responsibility to ask questions. This superb book exemplifies the power of the advocacy that doctors can achieve when they act collectively through national or international medical associations. Reading it made me feel proud to be a member of the BMA not my usual state through a hot summer. Holiday reading, it isn't. Essential, it is.

Iona Heath

The Paperless Practice

Simon Bradley
Radcliffe Medical Press, Oxford 2001
PB, 160pp, £19.95, 1 85775486 7

I must confess to cynicism on reading a title such as *The Paperless Practice*. The predictions for the paperless office don't seem to have yet come to pass and the most frequently used button on the computer is probably Print (I'll just run you off a copy!), and there you are – another 60 pages of bureaucratic miscegenation. Like the unlimited leisure that was predicted in the 1970s as the product of more and more automation, it hasn't quite arrived for me as yet.

I therefore opened the book with the schizoid view of one who believes that the information revolution is the single most

important thing to happen in medicine in the previous century but who has been exposed to disconnected projects, hobbyists, and minutiae mandarins who contrive to stop things happening. In a few minutes, however, the clouds started to roll away from my stormy brow and the sun broke through. Here is a man who books his holidays on the Internet and is writing part of the text in sunny Tuscany – he must be relatively normal.

This is a useful book. It's written in a friendly, conversational style and is divided into sections which could be more logically structured but which offer a pretty comprehensive overview of the opportunities open to practices in the information age. Written from the perspective of a partner who has taken his practice with him in developing information management, it describes useful techniques to engage the Luddite, gives practical tips on how to use e-mail and guides the confused through ways of simplifying result reporting and coding. The message throughout is that if you invest time and thought in planning what you do within your practice, rather than reacting to individual challenges, you will reap the benefits. Get coding and results input right and you will save time and effort later on. Imagine the future and you will be better capable of dealing with the present. How far off is the day that prescriptions will be sent electronically to a central warehouse and then delivered to the patient at home?

Much of the organisational detail is specific to England, emphasising the divergence of our UK health care experiments, and there are too many acronyms – but that is the curse of the NHS. The author has ignored the current morass of legislation on information handling where the arguments still seem to be about what should be the colour of the flag that the man walking in front of the train carries. Probably that is outside the scope of this useful, slim volume which will be of benefit to those looking for a framework for practice development.

So, paperless? I doubt it. Patient-focused, clinically useful data with finance and management automatically falling out of clinical transactions? That just might happen.

Gordon Peterkin

At all order this – 10 books from a lifetime of buying, browsing and (to a lesser extent) reading. So I imagine I'm off to that desert island – and have 10 minutes to scour my bookshelves and choose.

First: the incomparable *Elements of Style*, written by an American professor called Strunk and updated by his disciple White. After nearly a century, it is still the definitive book on how English should be written, and rarely is. Strunk and White live in journalism (though not, alas, in medical journals), so I shall take the *Beside Guardian* from 1991, a collection of articles on everything from Margaret Thatcher's demise and the Gulf War to broccoli, arguably the worst dish in the world.

Two more examples of fine journalism: Arthur Hailey's *Strong Medicine*, a fine description of the pharmaceutical industry under the guise of an airport novel, and Anthony Sampson's landmark book *The Anatomy of Britain*, which tried to trace the near-invisible threads of power running through our country.

Next, *Depiction of an Odyssey*, by the teacher and artist Peter MacKarell, who drew and painted his decline through multiple sclerosis, thereby reminding us that disease (though not death) can be conquered in many ways.

For some nostalgia: *Exciting Times in the Accounts Department*, the autobiography by the broadcaster Paul Vaughan. He evokes the BMA and World Medicine of several decades ago. With that, John Rowan Wilson's *The Side of the Angels*, (which I have on still on loan – sorry, Michael), said to use BMA worthies as the inspiration for a tale of Kremlin infighting at the height of the Cold War.

Another still to read: *Galileo's Commandment*, 2500 years of science writing from Herodotus, Da Vinci, Newton, Pavlov, Popper, *et al.*

My last two are the BMA's *Family Doctors Home Adviser*, whose algorithms have sustained me through a lifetime of hypochondriasis. And finally, the *Guide to Relais and Chateaux*, stacked with descriptions of fine hotels and fine food such as the ragout de lentilles vertes du Puy a l'oeuf de caille. Now that's what I call creative writing.

Investigations**Stuart A Kauffman**

Oxford University Press 2000

HB, 300pp, £10.99, 0 19512104 X

BIOLGY is like physics's kid sister. All soft and squidgy, it's an adolescent confection of puppy fat and carefully torn genes. Continually breaking out in unexpected directions, biology is in the middle of some prodigious transformation.

In fact, biology is rapidly growing up. Not in the sense of bigger laboratories, better techniques or more corporate investment, for biology has already left those growth charts way behind. But really growing up and coming closer to producing theoretical understandings that match those of thermodynamics and quantum theory.

It is this quest for some fundamental theory of biological systems that Kauffman tries to address in *Investigations*. What, for example, are the laws that allow living systems to continually co-create an ever more complex environment? What is it about life that so persistently keeps it from both stasis and chaos? And can answers to this sort of question be cast so that they hold true for all biospheres everywhere?

Over the past 20 years, schematic answers to these questions have emerged that, paraphrased, state that life typically stays at the edge of chaos: of all the possible states that a given system is capable of, living systems tend to inhabit (and co-create) that small, semi-stable region right on the edge of disorder.

But why? What is it about this region that makes complex systems choose them over all other possibilities? And how is this choosing done? Kauffman posits four fundamental laws to explain this. These are derived from the mathematics of complex networks and backed up by a variety of intuitions, speculations, and data. None of these is easy to grasp and the book as a whole is a difficult read. Other books (including Kauffman's earlier works) give a much more accessible view of complex adaptive systems.

Yet *Investigations* towers above these because it attempts a sweeping statement about the structure and limitations of biological knowledge itself. In a postmodern age which has set itself firmly against grand narratives that attempt overarching explanations, this is a book on a magnificent (some might say foolhardy) scale. Not for nothing is it consciously modelled on Wittgenstein's *Philosophical Investigations*. So what, if anything, has *Investigations* got

to do with medicine?

Well, at one level, not a lot. No-one is going to be out of a job because they don't understand this stuff. On the other hand biology is going to frolic all over this century, causing miracles and mayhem as it goes, and medicine will be its dancing partner. A cornucopia of new ways of manipulating the flesh, be it diseased or healthy, will transform the relationship of people with their bodies, and with their doctors.

Investigations sets out the fundamental steps of this dance. Here biology is no longer the kid sister, growing like topsy in every conceivable direction, warm and wet, a cacophony of diverse data, theory and achievement. Instead, glimpsed at the edges, a meta-theory begins to emerge, a General Biology, that explains why cells, or bacteria, or ecosystems, or families or evolution or economic systems, are the way they are.

Much of the detail of *Investigations* may prove to be wrong, but 30 years from now people will still be referring to it as a seminal book of the decade.

Paul Hodgkin

Plague Time: how stealth infection causes cancers, heart disease, and other deadly ailments**Paul Ewald**

The Free Press, 2000, US\$25, 0 68486900 4

WHOO is this book aimed at? The author assumes the medical establishment will automatically dismiss his title thesis and proceeds to alienate with an introduction that wouldn't be amiss in the tabloid newspapers. If I hadn't promised to review it, I would never have read beyond page six, thus confirming his opinion of us as inflexible and unwilling to entertain alternative theories.

After a sensational start, he launches into some very complex and firmly established science. At this point, despite a fairly detailed glossary, his explanations of microbial virulence and the immune response must leave all but the most motivated lay reader floundering. So who would be left, other than the dedicated reviewer who continues to be irritated, not because of his liberal use of the word 'germ', but because the germs inexplicably become microbes by the end?

Throughout the introductory chapters he keeps hinting at the main thesis. Through the last few chapters, he reiterates the same. In

How To Read *Investigations*...

1. Read one chapter at a time.
2. Retire to the bath, walk the dog, or embark on a high altitude walk.
3. Ruminat...
4. Make notes.
5. Repeat stages 1-4.
6. Proceed to next chapter...

fact, only a very small part of the book actually expands on it, and where I was hoping for something new, I was disappointed. He supports his theme with a good outline of the background to the now accepted microbial aetiologies of some chronic diseases, such as *H. pylori* and ulcers. There is a good account of the motion for the debate on *C. pneumoniae* and atherosclerosis and there is a reasonable synopsis of the story so far on viral aetiologies of neoplasia. The lay reader may take this selection as sufficient proof to accept his line, but I wanted more. It's a great thesis, and the author might be surprised to learn how many medical doctors already subscribe to his view.

The subtitle is the shame of the book. It may help to sell copies, but there is so much more to enjoy: The description of the background theories on the emergence, spread, and genetic variation of the HIV viruses is excellent. He explains the problems of antibiotic resistance and the need to control our use of antibiotics in a way that I will happily borrow for my students; but the real gem is his novel argument for investing in the infrastructure of the Third World and poorer areas of industrialised nations. The primary thesis serves as a framework to support his proposal to forget eradication and aim for domestication of our parasites. If we improve sanitation and separate ill people from the healthy and from the vectors of disease, then the only strains able to spread in the community are the less virulent, carried by the apparently healthy, isolation conferring a selective disadvantage to more virulent strains. He thereby presents a sound macroeconomic argument to allow people with even the mildest of head colds to stay away from work. A puerile suggestion compared with his call for insect-proofing of housing and clean water, but necessary in the context of the book.

The author devalues his book with his initial derision of doctors, a continual theme throughout. He supports this with historical examples, such as the slow acceptance of Semmelweis's incontrovertible hand-washing data. He would do well to acknowledge that it is easy for evolutionary biologists like himself to develop new theories, and for lay people to adopt them, but the technicians whose role it is to translate the same into practice would be wrong not to analyse and digest the data before putting patients at risk. There is much to be digested in this book, but very little to analyse. For that we will have to look elsewhere. I suspect that time may prove him right. Meanwhile, he needs to improve his writing style.

Marjory Greig

From the frontline

WE could smell the burning when the wind changed to the east, where we hoped that Foot and Mouth would stop at the river about five miles away. But then it jumped to the other side of us and we could see the pyres burning across Wigtown Bay. Rumour had it that a rogue dealer was to blame, with sheep bought back door from the sale in the Borders from which the epidemic initially had spread. And rumours abound. Prince Charles may think that the crisis has brought rural communities together, but the reality is more complex. Uncertainty breeds suspicion, which causes many to observe obsessive rituals through fear of blame. Contiguous culls were a strong incentive to be seen to do the right thing, although much of the evidence, like the official advice, was contradictory and confusing. But still we sprayed our wheels and dipped our feet in disinfectant. Meanwhile, social life slithered to a stop, with family birthday parties and local meetings cancelled, all against a background of uncertainty as to whether it made any difference or not. It could have been the wind which spread the disease or wild deer; perhaps we should shoot them all, and in some places they tried to.

After many years involvement with a family hill farm in Galloway it was salutary to think that carefully built up stocks of cattle and sheep might suddenly be slaughtered. We usually did the midnight shift in the lambing shed, but had to stop going to the farm because the practice where I work was in an infected area. Workload had not increased because farmers are realistic enough to realise that medication is no substitute for money, and counselling can not replace cash flow. In fact, there may be less work because there are fewer visitors, and tourism has been badly hit with bookings and therefore incomes often reduced by half. But there is always a silver lining for some, such as local contractors for the pyres and those doing the culling for good wages.

About 8000 farms in the UK have lost over four million animals, or nearer six million if calves and lambs are included. In Scotland, the main outbreak was in Dumfries and Galloway where 175 cases resulted in over 600 000 animals being slaughtered on 451 farms with another 900 included in the three-kilometre cull of sheep. The human cost has been devastating, with despair, uncertainty, and isolation for farmers and their families. All this, for a disease which rarely and mildly affects human beings, from which animals recover, and for which there is a vaccination. I know that vaccination is short term and we have export status to think of, but surely we should stop importing meat from countries with endemic Foot and Mouth. This was one of the recommendations of the report after the 1967 outbreak which was ignored, as were other recommendations, such as slaughtering infected herds immediately and burying onsite without delay.

Politicians tell farmers that the way ahead is to be paid as custodians of the countryside, but we already are. Five years ago, about one-third of the income for a hill farm came from subsidies, with the remaining two-thirds divided between the sales of calves and lambs. Now two-thirds of income depends on subsidies with only one-third from farm sales. To survive we have to contend with the beef special premium, suckler cow premium, sheep annual premium, hill aid scheme, slaughter scheme, organic food scheme, farm and conservation grants scheme, and environmentally sensitive area scheme, not to speak of animal passports. This all sounds depressingly familiar to a general practitioner, another victim of the managerial revolution.

No wonder doctors and farmers have such high suicide rates, but then perhaps this is just therapeutic writing.

OLD DOGS, NEW TRICKS

The British Association Festival of Science is one of the UK's biggest science festivals. It attracts 400 of the best scientists and science communicators from home and abroad, who reveal the latest developments in research to a general audience.

This year the Festival will be hosted by the University of Glasgow from 2-7 September with the theme of Science and Society. The Department of General Practice and the RCGP West of Scotland Faculty have jointly organised two sessions on Thursday 6 September in the Physiology Lecture Theatre, West Medical Building. The programme, which looks at the past, present and future of family medicine, includes speakers such as Professor John Frey, Professor Sir Denis Pereira Gray, Dr Graham Smith, Professor Martin Roland, Professor Fiona Ross, Professor Frank Sullivan and Dr Scott Murray. The afternoon session will be chaired by special guest Kirsty Wark.

Booking forms are available from RCGP Scotland, West of Scotland Faculty, 4 Lancaster Crescent, Glasgow G12 0RR. Please note that entry is free to GP tutors. RCGP members will qualify for the BA membership rate if they book through the College.

AUDGP ASM 2001, Leeds, July 2001... Altogether now!

THE Association of University Departments of General Practice (AUDGP) began, in the not-too-distant past, as a select band of GP teachers. Now, at least partly thanks to its success, the profile and breadth of primary care teaching and research have flourished exponentially, and the AUDGP has reflected this growth. Today it strives for and aims to represent the best in academic primary care (not just general practice) in the UK and Ireland, with its eye very firmly on the application of this to the delivery and deliverers of care. An increasing proportion of members, and the majority of new ones, represent disciplines other than medical, including sociology, nursing, health science, creative writing, and many others. There is increasing recognition among our members of the need to transform multidisciplinary lip service into practice.

This year, Leeds saw the Association's Annual Scientific Meeting in July. The central theme of the conference was Getting it Together, with a view to presenting and considering the many ways in which the disciplines involved with primary care must work with each other and with external disciplines. Four sub-themes were developed, reflecting the Association's areas of interest: primary care research, primary care education, patient care, and cross-disciplinary working.

In total, over the four sessions, there were 270 presentations, including 171 posters, seven workshops, five plenary talks, 85 other oral presentations, and an opening and closing address. The range of subjects was breathtaking and, in many cases, so was the quality. The opening address, by Graham Watt from Glasgow, set the scene for both. With characteristic erudition and eloquence, this deeply-considered discussion explored the role of academic general practice, with reference to the Inverse Care Law. Our role is to inform the decisions of patients, professionals, managers and politicians, and therefore to influence the future of primary care. However, if we are tempted to trumpet our success, we also need to consider why one of the earliest findings of primary care research remains essentially unchanged. The Inverse Care Law persists, less now for reasons of uptake of care, but more because effective clinical interventions are harder to establish, evaluate, and provide in areas of socioeconomic deprivation, and research often specifically excludes these areas or individuals. We need to employ all the skills within our discipline to address these problems.

Such pursuit of equity was a recurrent theme in the subsequent presentations, whether this was by promoting the values in our students (Amanda Howe, East Anglia), improving access to care (Sheila Dilks, Chester), or by setting appropriate quality indicators for equitable assessment of practice (Stephen Campbell, Manchester). Others presented the innovative; for example, problem-based CD-

ROM learning (Ivan Appelqvist, Sheffield); involving patients in setting quality standards (Keith Stevenson, Leicester); and electronic prescribing (Terri Porteous, Aberdeen). Yet others presented the creative: the epidemiology of Uncle Norman and the last person (Alex McConnachie, Glasgow); attitudinal objectives in undergraduate curricula (Anne Stephenson, London); and culminating in the best example of creative collaboration in current academic primary care the Scottish School of Primary Care, a virtual institution, presented by its foundation director, Sally Wyke.

The intellectual pistons throbbed right to the conclusion. Chris van Weel, President of the European Society of General Practice considered, in a thought-provoking lecture, the contribution of general practice to society, from small communities to the whole continent. General practice, if defined by its core values of individual and family care, solidarity with the sick, and personal care, is fundamental to any just society. This holds communities together, and the particular challenges faced by practitioners (including dealing with undifferentiated illness, managing most episodes of illness without referral, continuity of care, and equality of provision) should hold us together, transcending boundaries and borders.

Two new linguistic contortions were introduced to my vocabulary. More than one presentation compared benefits with disbenefits, a concept for which I can only perceive self-referential value. Another speaker bemoaned a meeting on disability research, at which every speaker was a non-disabled person: he would prefer these double-negative speakers to have cancelled each other out.

I need not delve too deeply into the social programme, for reasons of propriety. Excellent company, food, and wine fuelled both evenings energetically. The Royal Armouries, the Thackray Medical Museum, and traditional curry-related venues provided appropriate backdrop for the combination of intellectual and bawdier discourse. I have to report a recurrence of the traditional tendency for Scottish and Irish social sedimentation. My lasting memory is of an animated discussion about systems of primary care with the eminent editor of a primary care journal (not this one), amid a heaving dancefloor, each of us clutching a full bottle of wine hoovered from the recent dinner table.

The AUDGP is undergoing a contemplative re-structuring of its aims and membership, with a view to opening up, expanding, and facing the future. This move is supported by the members, and, given the breadth and depth of the vision apparent at the ASM this year, it will be successful. You can write this next year.

Blair Smith

Alcohol Concern — Primary Care Information Service

Alcohol Concern is launching a new service for professionals to support alcohol work in the primary care setting. The RCGP have agreed to support the initiative by providing a direct link to the Primary Care Alcohol Information Service (PCAIS) from the College's website.

Funded by the Department of Health, the aim of PCAIS is to raise awareness and stimulate interest in alcohol issues among primary care professionals. PCAIS provides a telephone information line, a news bulletin, fact sheets, and web pages aimed at sharing good practice between primary care workers at the frontline of prevention and treatment of alcohol-related problems.

For further information about PCAIS, contact Anna Wood, Primary Care Information Officer, Alcohol Concern, Waterbridge House, 32-36 Loman Street, London SE1 0EE; tel: 020 7928 7377; fax: 020 7928 4644; e-mail: contact@alcoholconcern.org.uk; URL: www.alcoholconcern.org.uk

Extending the registrar year

I have just completed 18 months as a GP registrar. And yes, before you ask, this was a planned extension of the training period spent in general practice, and I recommend it!

Since April 2000 the training budgets for registrars have been held by the regional deaneries rather than coming from GMS funds. This has enabled the funding of more innovative training posts.

In the West Midlands region a number of registrars, including myself, have recently had the opportunity to undertake a six-month extension. The focus of these posts has been to develop an interest in inner-city general practice in the hope of improving recruitment and retention. It has involved spending three days a week in an inner-city practice working as a GP registrar. The remaining two days were for self-directed learning, determined by educational needs, individual interests and broadly concerned with the needs of deprived populations. Examples of such activities include: working as clinical assistants at GU clinics, involvement with community drug teams, family planning, and attachment to outpatient clinics. More structured posts have also been devised, for example on women's health, or diabetic care. Similar schemes have been piloted in London.¹

Why do I recommend this extra training? I have been able to pass four further modules of assessment, namely the MRCGP exam. The pressure to complete both this and summative assessment in the traditional year can be a hindrance to making the most of the experience of being a registrar spending time with patients, and learning.

Why the great rush anyway? Which other speciality trains their registrars for just a year? None of my peers are going straight into partnership from their training jobs. All are locuming, taking salaried posts, or travelling. The extra time spent becoming familiar with the administrative and political aspects of primary care has increased my confidence to consider becoming a real GP. I have been able to see the workings of more than one practice, which has helped me clarify my own preference for size and style of partnerships.

I enjoyed taking the initiative, learning what I needed to learn about GU medicine, TB and chest disease. Inner-city practice taught me about drug addiction and problems for asylum seekers. I have gained knowledge and skills that will be of value as primary care expands and evolves.

One day all GPs should be trained like this.

Simon Loader

1. Norris GF, *et al.* Extending vocational training: the registrars' perspective. *Educ Gen Pract* 2000; **11(4)**: 420-425.

neville goodman

Anaesthesia Milanese

WELL, what would you do with an e-mail entitled SMART2001 whose sender was Fabrizio in Milan? I deleted it, along with sundry exhortations to improve my credit rating and enlarge my penis. But the fourth time in a week that Fabrizio's message appeared in my mailbox with exactly the same subject and sender I did start to wonder. SMART2001 turned out to be the acronym for the main joint meeting of three Italian anaesthesia societies. It was being held in Milan. The e-mail was an invitation, all expenses paid, to give a lecture. I guess it pays not to be too paranoid.

I learned a lot at the conference. I learned the main difference between First Class on GWR trains and Club Class on British Airways: the overweight bloke in the seat next to you telephones someone to tell them, I'm on the plane. He telephoned two people to tell them that, as well as promising to telephone after landing. I was pleased to see that his telephone failed to dial through on the tarmac at Milan.

I learned that the Italians know how to organise a good conference. The general tenet was to organise it around breaks for decent drinks strong coffee, fresh orange juice, still or fizzy water and excellent food. As it was 33 C outside most of the time, the liquid was essential rather than merely convenient. But the content of the lectures was good too, and the simultaneous translation excellent. Listening to one speaker, I was the only person wearing headphones, and it was a large lecture theatre. Either lots of non-Italians speak Italian, or I was just about the only non-Italian in the room. Whichever, it showed there are certain advantages to understanding English.

The conference was in Milan fashion centre of the world and shopper's paradise but in name only. Nothing in the centre of the city can support a conference with 3000 delegates. We were condemned to a glass city out beyond the ring road. There was endless brightly reflective plate glass, draped by concrete steps lined with steel railings, looking out over curiously sterile green lawns. Wandering across the middle of one of these in the stifling heat, I felt in a dream from which I would never escape, doomed forever to turn the next corner and find yet another lawn, surrounded by yet more hermetically sealed, fire escape-clad, glass.

But I didn't miss the shopping, because two weeks later I spoke at another conference, in Aberystwyth.

our contributors

Tim Albert is a writer, trainer and frequenter of GP surgeries. His latest book, *A-Z of Medical Writing*, was published last year by BMJ Books; tatraining@compuserve.com

Donald Coid is an Honorary Senior Lecturer in the University Department of Epidemiology and Public Health at Ninewells Hospital and Medical School, Dundee

Marjorie Greig is a formidable microbiologist, in Chichester. She trims the mainsheet in a competitive Sigma 33, and can fall asleep on tarmacadam

David Hannay sails, in the Solway Firth

Iona Heath sails, in Sweden

Paul Hodgkin sails, in the Hebrides, where he entertains crews during weary passages under power by talking rather as he writes ... more at hodgkin@primarycarefutures.org

Simon Loader is married to Andrea (not Nancy) and she is expecting twins imminently to bring their tally of children to three. So not much time for sailing there

Dorothy Logie travelled to Genoa in search of a good riot but ended up in Milan, sipping espresso for insurance purposes, much to the disappointment of her many editors. Full story at delogie@aol.com

Ann McPherson devised DIPEX with Andrew Herxheimer. She is a GP in Oxford

Gordon Peterkin is a former GP from Forfar and is now Medical Director of Grampian Healthcare

Trefor Roscoe reaches coronary risk factors faster than your average health informaticist. See bmj.com/cgi/eletters/323/7307/246#EL2

Martin Scott lives in Sheffield and is currently studying for an English degree. gary@flockton48.freeserve.co.uk

Blair Smith is a member of the *BJGP* Editorial Board and a GP in Aberdeen

Fiona Smith is the manager of The St Paul RCGP Quality Unit

Jeremy Strachan is Secretary of the British Medical Association. Previously he was a senior corporate lawyer for the pharmaceutical company, Glaxo SmithKline

James Willis is keen that the world looks at his website ... www.friendsinlowplaces.co.uk soon to feature lots of Blake

Tim Wilson is director of the RCGP St Paul's Quality Unit.

All of our contributors can be contacted via the Journal office

Logical conclusion

These Back Pages have, as the Editor pointed out last month, always been a refuge for those who find numbers unsatisfying. I think he probably counts me in this number as I've been here on and off from the start. Four years ago, it was: 1997. Which is a long time, longer than he has been editor in fact, but hardly while we are being numerate hardly always. I am not just being pedantic here, this is an important point.

William Blake was numerate. I have a tip for those wishing to write for the Back Pages: mention Blake. Front Pages: mention computers. Back Pages: mention Blake. All editorial discretion will evaporate in each case. That's how I do it. Your weirdest thoughts appear, like magic, before the startled eyes of thousands.

Blake was a technician before he was an artist. This is another important point. Like most artists and writers down the ages, he couldn't make a living from that kind of work. And right until the end of his life Blake supported his family as a journeyman engraver. Hard, skilful work it was and he was a consummate master of his craft. He even invented his own technique. Radically new. Cutting edge stuff, the high-tech of his age. Thus his books, displayed last summer in Tate Britain, were an extraordinarily personal creation: He wrote the poetry, designed the illustrations, engraved the plates (using the method he had invented), printed them and coloured them. He even did his own marketing, hiring a friend's rooms for an exhibition that hardly anyone attended. This man ought to be the patron saint of general practice.

But Blake had his other side, just like general practice, and just like these Back Pages. For him science had an evil aspect, linked with his dark, satanic mills, which he saw embodied in the person of Isaac Newton. He painted that great scientist underwater, naked, in the act of measuring, with a pair of sharp dividers, a triangle which symbolises the Holy Trinity. He shows Newton staring, unblinking, straight at God. Man seeking to know the unknowable.

In comparison with this graphic attack, Back Pages articles are anaemic and deferential in tone. Suffice it to point out that it was Newton who got it wrong, not Blake. The arch-enumerator's sums have not stood the test of time: Light, on the cosmic scale, no longer travels straight. Actions, on the quantum scale, just happen, without cause. Einstein put it, 'In so far as the statements of geometry speak about reality, they are not certain, and in so far as they are certain, they do not speak about reality.' Now, for the first time in history, man is using powerful logic machines to try to measure life, and he is finding that the sums don't add up. Life, in short, is a great deal more complicated and subtle than numbers make it seem. Those of us with a great deal of experience of life and general practitioners in the privacy of their consultations can make this claim with more justification than most are right to challenge naively-held theories that do not match the reality they see.

As readers of the *BJGP* come through the Front Pages to the Back, so we doctors come through numeracy and carry it with us in our work. A powerful tool, a strong defence, sometimes indeed a satisfying tool. But never sufficient. And also open to terrible abuse. Those who wield numbers wield enormous power. Numbers can simplify and distort perceptions of what is important. They can be agents of a modern tyranny, which must be opposed.

The thing I found so moving about the Tate's Blake exhibition, having read Peter Ackroyd's biography some time before and Raymond Tallis's book, *Newton's Sleep*, was that it included a reconstruction of the exhibition that Blake and his wife, never doubting the value of his work, once prepared so lovingly together. And (excuse me, I'm a romantic) after all these years the whole world came.

*'May God us keep
From single vision & Newton's sleep.'*

William Blake
Letter to Thomas Butts, 22 November 1802.