The Back Pages

viewpoint

DTCA in New Zealand: The challenge of finding an acceptable balance

THE United States and New Zealand are the only two industrialised countries that allow direct-to-consumer advertising (DTCA) of prescription-only medications. In NZ this happened by default because there was no specific legislation preventing it. In the past few years this method of promoting pharmaceuticals has grown exponentially, mainly via the powerful medium of television. Unlike the US, in NZ the majority of the cost of prescription medication is paid for from general taxation; thus DTCA has raised the issues of equity and distributive justice that will apply in the UK and much of Europe. Following a high profile advertising campaign for a slimming medication, NZ's Ministry of Health produced a discussion paper and invited public submissions.[1] As expected, submissions from the pharmaceutical industry and advertising agencies were universally in favour of DTCA; submissions from the drug purchasing agencies were equally predictably in favour of a ban on DTCA. What was perhaps surprising is that three-quarters of submissions from the public were against it — equivalent to the proportions from the medical profession.[2]

So how is DTCA evolving in a climate of minimal and ineffective self-regulation? Prime time television is punctuated by advertisements extolling the virtues of various drugs. Messages are often misleading. Information is brief, usually relating to efficacy with little mention of safety, and none of cost; there is usually a final suggestion to 'go and talk to your doctor'. Of the increasing proportion of prescription-only medications advertised, many are unsubsidised, mainly lifestyle drugs (such as Viagra and Xenical); others are fully subsidised high-volume drugs, such as asthma medications. Because visits to GPs are only partially subsidised, many advertisements list free 'helplines'. GPs are faced with extra consultations to discuss the relative risks and benefits of an advertised product. Mutual trust is a cornerstone of the modern patient-centred doctor–patient relationship and such encounters often leave both patient and doctor feeling dissatisfied.

Whatever the arguments against it, increasing DTCA on the internet, in magazines, and on TV, seems inevitable. Billion-dollar profits are at stake. Voluntary regulation has not worked in NZ and compliance monitoring is expensive.

So what are the questions that need to be asked? Can DTCA of prescription drugs be of net benefit to the public health (or the public purse)? How can a publicly funded health system with a finite health budget cope with this extra burden? What will be the opportunity costs to the system and to the prescriber's time? Decisions for change within the health system should be evidence-based. Is there strong evidence for benefit to anyone except the pharmaceutical companies? Is there evidence that this is the best or indeed an acceptable way to educate and inform consumers in a balanced way? Indications from consumer submissions would suggest this is not their preference. Is there evidence that the changes in prescribing, which will inevitably result, will offer improved health outcomes? Most importantly, what is the evidence for the harm — to the individual who applies pressure to their GP for a drug they would not have otherwise prescribed, to the GP–patient relationship, and to the publicly funded health system which must spend money regulating and trying to balance the selective pharmaceutical messages?

Unfortunately, it is difficult for the profession to oppose DTCA without seeming to protect a position of power. However, it must be remembered that, unlike Health Maintenance Organisations in the USA, GPs in NZ gain no financial advantage from the prescription of a particular drug. Arguably, they are still in a position to take a broad view of the greater public good — acting as a learned intermediary who does not have a pecuniary interest in the product dispensed.[3] Access to relevant information should not be allowed to exacerbate the increasing medicalisation of health. The promotion of pharmaceutical solutions to lifestyle problems, together with the imbalance of resources available for pharmaceutical versus non-pharmaceutical research, combine to form a powerful driver for the 'pharmaceuticalisation' of health.

So we are faced with some choices: 'Don't Tell Consumers Anything', 'Drugs To Cure All' or 'a common-sense compromise'?

Les Toop
Derelie Richards

References

1. *Direct To Consumer Advertising of Prescription Medicines in New Zealand: A discussion Paper.* Wellington: Ministry of Health, 2000. URL: www.moh.govt.nz
2. *Summary of submissions on the direct-to-consumer advertising of prescription medicines in New Zealand.* [Discussion Paper.] Ministry of Health: Wellington, 2001. URL: www.moh.govt.nz
3. Drazen JM. The consumer and the learned intermediary in health care. *N Engl J Med* 2002; **346(7):** 523-524.

"Homelessness ... has to be considered foremost as a symptom of an underlying rag-bag of problems — an endpoint of numerous different downward-spiralling paths that will usually be unresolved by the provision of housing alone ..."

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"Marked by the movements of the heavens and the motion of clocks, titrated in schedules, timetables, appointments and diaries, in growth charts, kick charts, temperature charts and scans, time is embedded in our clinical representations."

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"Prescribing an antibiotic for an URTI doesn't seem as bad in a five-minute appointment, as in a ten-minute one."

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Homelessness and health: Leeds conference

I'd slept poorly, apprehensive of the rigour of the following day's travel timetable and disturbed by nocturnal comings and goings around me. I woke early, pulled on my appropriate homelessness clothes, and embarked on my long journey. I suffered the anxieties of someone not used to the commuter's time-honed routine — having gone hungry and yet knowing that I would surely arrive late because of the necessary compromises with the train timetable, and uncertain of finding my destination quickly.

When I arrived 15 minutes late at the Le Meridien Queen's Hotel in Leeds, conveniently situated by the railway station but otherwise totally unlikely, it was perhaps unsurprising that, unable to communicate on any level with the bizarrely uniformed doorman, he somehow got jammed with me in the doorway.

There were no seats that remained easily accessible on a row end, and no-one indicated that I would be welcome to pass by and sit next to them. I drew a chair up from the rear of the imposing room and sat a little apart.

The initial address was in progress. It was telling me nothing that I did not already know; it seemed to miss the point as I saw it. The speaker obviously inhabited a different world, spoke academically, was smartly dressed, confident. Her agenda did not meet mine. All of this created emotions that at the time I could only dimly understand, could not easily put into words — echoes of past traumatic experiences. We were invited to ask questions, but I wanted to make statements. They would have sounded angry, probably inappropriate, so I said nothing and waited.

If I'd just had my first litre bottle of cider … or was shivering, snivelling and aching before my first hit of the day, I would have probably shouted something extremely aggressive and offensive, ranted on and been asked to leave; if I'd been depressed I might have just got out of that hotel and out of my head. But luckily for me I've been here before.

I've got some self-esteem. I know other people often have similar feelings to me and they're not totally abnormal; that if I talk to that speaker afterwards I'll probably find I've misunderstood her. There'll be other people here who'll share my concerns and the rest of the day could be great. I might even discover my prejudices.

Homelessness, it seems to me, has to be considered foremost as a symptom of an underlying rag-bag of problems — an endpoint of numerous different downward-spiralling paths that will usually be unresolved by the provision of housing alone. Undoubtedly, it is a problem itself which may compound all that has gone before, and in addition have it's own debilitating consequences.

As the day progressed, all this was said, and much more; the RCGP statement on homelessness was rewritten with a great feeling of consensus to overcome my misgivings — you may have read it by now or else soon will.

I won't go over the detail of the day; but some recurring themes stand out:

- Homeless people are vulnerable, even if they present as aggressive and difficult; it must be understood that anger and aggression are symptoms, and violence is a response to hostility (perhaps there are few violent patients but too many aggressive surgeries).
- There are benefits in inter-agency collaboration, as it allows differences to be overlooked and new solutions to be found when meeting and working with other professionals.
- Creating a home for the homeless means providing for many needs as well as the need for a roof.
- Strategies should be found to help people who need rehabilitation but cannot stop

using drugs, and to house the unhousable — those banned from everywhere and who keep dropping out of the system.

- The provision of specialist GP services — they should not be the cause of de-skilling of the mainstream GPs but should, on the contrary, be a learning resource for them.
- Asylum seekers need to be valued and interpreting services should be universally available.
- There is a need for appreciation of the extra time and money needed in primary care for addressing the problems of those with complex needs.
- There should be access to non-discriminatory specialist services (especially for the chaotic, the mentally ill and the substance abuser) that focus on problems rather than diagnoses, harm reduction rather than cure.
- Plans for the sharing of electronic patient records must be speeded up.
- There is a need for a recognised qualification and structure for nurses working in the area of social exclusion.
- There should be recognition that there are some people who have a different philosophy of life to one's own and that, for example, they might need or want to keep taking drugs, remain a nomad, or accept that life for them isn't ever going to be as fulfilled as we think it should be.

There is a relentless practicality about the use of large hotels for conferences, and apart from the foyer and the ridiculous doormen it wasn't so very pretentious, I suppose. But some joker (or ironic chance) rang the fire alarm at one point during the day and we found ourselves for fifteen minutes carrying on our earnest discussions in the most appropriate of places — on the street.

Simon Tickle

patient participation series - 1

Prologue

'Too much politically correct pussy-footing goes on when patient participation is on the menu', says the *BJGP*'s Deputy Editor, so would we tell it as it is. To begin at the beginning...

During my first year (1995–1996) as a member of the Patients' Liaison Group (PLG), its agendas averaged 12 items. The four or five meetings a year often finished at lunchtime and sometimes there was an afternoon subgroup meeting of, for example, the group which oversaw the production of the very successful 'How to work with your doctor' series of leaflets. Nowadays the agenda items average 21; we hope to finish by 4.00 pm.

Seven lay members plus five GP members makes a good size of group for discussion; one visitor to the group said he found it difficult to know who were the lay members and who were the GPs. Certainly, we all enjoy and learn from the discussions. The variety of background experience (see the College's website: Patients' Centre) obviously contributes to this. To give you a sample of discussions during the past year: epilepsy and pregnancy; the removal of patients from GPs' lists when patients move to residential homes; female genital mutilation (resulting in a *BJGP* article and a section on the College website); CancerBACUP; GP home visits; explanation of GPs' qualifications; explanation of commonly used medical abbreviations; continuity of care; training of doctors from overseas; revalidation; accredited professional development; and confidentiality of patient records.

The RCGP was a pace-setter in establishing a patient group in 1986. In recent years it has followed on by inviting lay members on to its committees and working groups, thus demonstrating its preparedness to listen and be open. The additional meetings stretch PLG members' availability, but add to our understanding of College work. It is now possible for a lay member to find that he or she is the only person on working group X who also serves on committee Y and has a link to make in relation to work in each sphere. We report back to the PLG on these additional meetings.

Some years ago, lay members of the PLG were given the opportunity to train as assessors for Fellowship by Assessment and this was taken up enthusiastically. Visits have taken me to Aberdeen, Edinburgh, Bristol, Devon and Cornwall, and memories from these visits have provided lasting impressions of GPs with great enthusiasm for the job, a willingness to reflect on their work, and implement changes. Furthermore, it's noticeable that GP assessors seem to take away ideas for their own practices. All in the best interests of patients one way or another.

Since 2000 the PLG chair has been given a seat at Council meetings as an 'observer' (which allows contributions to the debates, but no vote obviously). The papers are given a 'taxonomy category' (a bit startling if you associated that with natural history). PLG meetings are now scheduled so that members have the chance to comment on Council agenda items. Members are also given the opportunity to comment on many of the external consultation documents to which the college responds. And, since 2001, the chair has had a seat (observer) at Council Executive Committee meetings.

Despite the formality of Council meetings (well, it is a huge gathering and needs to be disciplined) individual members of Council make the patient welcome and build bridges in the way that GPs do. The debates can be thought provoking (a new angle), entertaining (some frustrated actors here), or boring (having been a trustee of a charity for ten years the cyclical: subscription levels, retaining members, revamping the journal). Eventually I realised that the bustle associated with coffee/lunch breaks — the short conversations followed by 'moving on' — equates with a series of GP consultations.

One interesting line of progression has been membership of the RCGP's Good Medical Practice (GMP) for General Practitioners Working Party, overlapping with the Revalidation Working Group, in turn overlapping with the Accredited Professional Development Implementation Team. Again it was good to realise that the College was setting the pace in producing GMP for GPs, accepting the need for revalidation and planning its response. An impressive amount of work and enthusiasm have gone into the in-house work and GPs' preparedness to pilot the scheme and review the resource file. We also now have lay involvement in the Fellowship Committee and the Primary Care Research Team Assessment Advisory Group.

So the four or five meetings a year have metamorphosed to four or five meetings a month plus preparation plus follow-through plus incidentals plus unreliable train journeys. And yes, I could say some tougher things by way of 'telling it as it is' (such as the fact that patients are not the only ones with axes to grind) — but I see the role as working with, not against GPs, in the interests of patients.

Eileen Hutton

Time, a narrative organiser of events and ex

This paper is an adapted and compressed version of 'Biological and Narrative Time in Clinical Practice' to appear in: Holmes J and Elder A (eds). *Narrative in mental health and primary care*. Oxford: Oxford University Press, 2002.

' ... the ticking of a clock. We ask what it says: and we agree that it says tick-tock. By this fiction we humanise it, make it talk our language. … tick is our word for a physical beginning, tock our word for an end. What enables them to be different is a special kind of middle.'

Frank Kermode. *The Sense of Ending*.[1]

Introduction

Neither seen nor felt directly, nor heard, tasted or smelt, time is dimensional to being and inherent in the practice of medicine.[2,3] Clinical encounters focus typically on temporal sequences, on relations of before and after, on discussions of beginnings and endings. Some conditions are associated with slow, unfolding awareness of difficult-to-pinpoint feelings, others with instantaneous, 'thunderclap' experiences; extremes encompassing a spectrum of sensations that 'come' and 'go', move about with unaccountable tempo and which vary in quality, intensity, and rhythmicity.

I recently registered one of my patients as blind and pondered the long time course of her visual deterioration and whether blindness could have been prevented. I have been Barbara J's GP for 16 years and during that time have come to know her well. I've written her many a note about aspects of her care; concerning letters from hospital specialists, abnormally high blood glucose results or missed clinic appointments, to which she has always responded.

During the period of our relationship, the suspected link between onset of diabetic complications and blood glucose control has become clearly delineated.[4-6] The product of average blood glucose concentration and time has been found to predict onset of retinopathy. Two unfelt risk factors — a composite of time and metabolism — are thought to exert harmful effects. Findings such as these underpin health care strategies aimed at modifying today's risks to prevent tomorrow's undesirable outcomes, and undercut Leriche's view that 'health is life lived in the silence of the organs'.[7]

Time frames

Biologically and narratively, time flows in the direction of causality along an axis extending through 'before' and 'after', providing a temporal matrix for the continuous processes of growth, development, and ageing. Our human span is marked by segments attended now by particular specialisms — embryology, foetal medicine, paediatrics, gerontology — each making common use of time: in their selection of screening and re-screening intervals, in setting out medication regimens, temporal courses of treatment, periods of risk, incubation, infectivity, and recovery.[8]

A measurable duration spanning events and actions, Aristotle considered time the 'calculable measure of motion with respect to before and afterness.'[9] In the unending flow of occurrences marked out by 'before' and 'after', time provides the framework in which positions, sequences, values and

Box 1: A GP consultation and the temporal order of things

Michael, a crane driver, had always assured me he was HIV negative. An intravenous heroin user for whom I was prescribing methadone, he insisted further HIV tests were not necessary: he'd had three tests while in prison and these had shown him to be negative.

I realised Michael had a girlfriend — also a patient of mine — and I quizzed him again about his HIV status and whether he'd discussed the risks with his girlfriend. He hadn't, because he thought himself to be negative.

He let me write to the Prison Medical Service for details of his test results. Three HIV tests had indeed been performed, over a period of 12 months, the last of which was positive. Michael had been informed, and offered monitoring. That was four years ago.

When I next saw him I asked again about the tests. Michael knew the third one had been positive, but seemed unconcerned about it. To him, two out of three tests — a clear majority — were negative. The order in which test results were declared was not of itself significant to Michael who seemed to deny that two negative tests followed by a positive result more likely signified he was infected than an initial positive result followed by two negative results.

functions are compared and juxtaposed. Delineating occurrences along the axis of time's arrow allows key clinical relations to be charted: 'For how long have you had these symptoms?', and 'Were they troublesome before (or after) your wife died?', are questions aimed not only at clarification, but at discerning a concomitant flux of events.

Lacking itself material qualities, time has been judged the necessary presupposition of experience and thought. Existent or not in the universe, anthropologists report no cultures lacking a concept of it. In shaping ideas and experiences of time, Edmund Leach believed repetition to be the key: 'Drops of water falling from the roof are not all the same drop, but different'; to recognise them as different we must first distinguish and define intervals of time: 'Time intervals and durations always begin and end with the same thing, a pulse beat, a clock strike',[10] a conception that marks time out metronomically but fails to capture how it is experienced, or recounted.

We term the second of the two related clock sounds 'tock' (not 'tick'), Frank Kermode suggests, precisely to defeat the tendency of the interval between tick-tick to empty itself of any meaning other than mere duration and chronicity: 'The clock's tick-tock I take to be a model of what we call a plot, an organisation that humanises time by giving it form … Tick is a humble genesis, tock a feeble apocalypse'.[1]

Narrative and time

Kermode alludes here to the narrative devices of stories, in which duration and meaning are structured by a beginning, middle, and end. His insight is pertinent to clinicians, who spend much of their lives listening to story fragments and searching for connections between feelings and bodily processes, where precise temporal relations, the order in which events unfold, can be crucial signifiers of meaning and significance (Box 1).

Galen conceived symptoms to be special experiences which disclose disease as reliably as a shadow follows the body on a bright day.[11] Over time, changes in internal environment variably coded and encapsulated in language give rise to symptoms. Yet in encoding, recalling, and communicating such experiences, processes of narrative selection and classification take place.[12,13]

Narration involves recounting, shaping and the ordering of events ('emplottment'). Though often fragmentary and episodic in clinical settings, it is through the telling of stories that we make sense of our world:

Box 2: Author's preface from *To the Hermitage*

'This is (I suppose) a story. I have altered the places where facts, data and info, seem dull or inaccurate. I have quietly corrected errors in the calendar, adjusted flaws in world geography, now and then budged the border of a country, or changed the constitution of a nation. A wee postmodern Haussman, I have elegantly replanned some of the world's greatest cities, moving buildings to better sites, redesigning architecture, opening fresh views and fine urban prospects, redirecting the traffic. I've put statues in more splendid locations, usefully reorganised art galleries, cleaned, transferred or rehung famous paintings, staged entire new plays and operas. I have revised or edited some of our great books, and republished them. I have altered monuments, defaced icons, changed the street signs, occupied the railway station. I have also taken the chance to introduce people who never met in life, but certainly should have. I have changed their lives and careers'.[21]

'It is through hearing stories about wicked stepmothers, lost children, good but misguided kings, wolves that suckle twin boys, youngest sons who receive no inheritance, live riotously and go into exile and live with the swine, that children learn or mislearn both what a child and what a parent is, what the cast of characters may be in the drama into which they have been born, and what the ways of the world are.'[14]

A fundamental part of discourse and culture, some investigators view story-telling as part of our evolutionary survival kit. The experimental neurologist, Antonio Damasio, for example, suggests that tripartite narrative structures have parallels (and biological substrates) in the excitatory processes of perception and memory. Damasio understands the interactions of organisms with objects — in perception and memory — to be 'simple narratives without words' and believes that narrative categories offer a key to unravelling the basis of consciousness.[15]

Beginnings offer connections

Beginnings designate a point in time, place, action or intention at which a process or idea first comes into existence. Edward Said explains: 'beginning is designated to indicate, clarify, or define a later time, place or action', above all to signify precedence in relationship, the first step of something relating to what follows.[16] To speak of a beginning signifies the initial manifestation of something in life, or in literature, that has duration and coherence of meaning. Whatever belongs to the beginning endures, at least for a while, being connected (in some way) to subsequent events or consequences.

With no necessary connection between beginnings and causes, beginnings nevertheless are infused with causal significance. Experiences manifesting narrative kinds of belonging put feelings, sensations or events into an order of sorts, frequently a successive, chronological one. But although time is almost always constitutive of narrative, temporal succession is not sufficient to make a story. It is by establishing that occurrences and episodes are linked together (logically, biologically, historically or genetically), that narrative coherence in medicine is manifest.[17] The pain of shingles, for example, heralds the beginning of a condition that generally unfolds predictably over time. Not itself causative of the rash by which shingles is more usually diagnosed, prior connections, temporal, clinical and pathological, link pain of this sort — its clinical beginning — with the subsequent onset of a distinctive rash, allowing early identification, treatment and sometimes early curtailment.

Listening to stories

To listen, remember, and interpret the many fragments of experience patients bring to consultations requires sympathy, patience, and particular attention to temporal patternings. These are aspects of sensibility not dissimilar to those involved in appreciating stories.[18,19] A meticulous concern for narrative devices, for relations of succession, association, and causation, an attentive interest in the unusual, in deciphering and piecing together the meanings of words, gestures and expressions, are capabilities required of good clinicians. But the narrative content of medical consultations can be very different from that crafted by literature. In literature, stories need not be constrained by a simple chronology; positions in time may vary, even reverse,[20] and assumptions concerning reality may be relaxed.

Malcolm Bradbury has sketched out the fictive stance he adopted in his last book, *To*

Box 3: So Many Different Lengths of Time

How long is a man's life, finally?
Is it a thousand days, or only one?
One week, or a few centuries?
How long does a man's death last?
And what do we mean when we say, 'gone forever'?

Adrift in such preoccupations, we seek clarification.
We can go to the philosophers,
But they will grow tired of our questions.
We can go to the priests and the rabbis
But they might be too busy with administrations.

* * *

So how long does a man live, finally?
And how much does he live while he lives?
We fret, and ask so many questions —
Then it comes to us
The answer is simple.

A man lives for as long as we carry him inside us,
For as long as we carry the harvest of his dreams,
For as long as we ourselves live,
Holding memories in common, a man lives.

His lover will carry this man's scent, his touch;
His children will carry the weight of his love.
One friend will carry his arguments,
Another will still share his terrors.

And the days will pass with baffled faces,
Then the weeks, then the months,
Then there will be a day when no question is asked,
And the knots of grief will loosen in the stomach,
And the puffed faces will calm.
And on that day he will not have ceased,
But will have ceased to be separated by death.
How long does a many live, finally?

A man lives so many different lengths of time.[28]

Box 4: Time's Chariot

The feeling that most of us have that the first ten years of childhood lasted much longer than the hectic decade of 40–50 is no illusion … biological processes, such as wound healing, operate much faster (in terms of stellar time) during childhood than in old age. But since our sensations are geared to our biological processes rather than to the stars, time's chariot appears to proceed at ever increasing speed. This irregular flow of biological time is not merely a phenomenon of personal intuition; it is observable in the organic world all around us. Plant growth is much faster at the beginning than at the end of the lifecycle; the ripening of the grain and the sprouting of the sown grain proceed at quite different rates of development.'[10]

the Hermitage.[21] In alluding to transformations in time, place and landscape, he successfully awakens our interest in the story's formal features, including its period and perspective, and staked a claim for the authorial omnipotence of the novelist (Box 2).[22] Though clinical narratives are clearly constrained in ways fiction isn't, they too may jump about in time, place and temporal sequence. Alteration of perspective enables significant changes in interpretation to be achieved, the proverbial wisdom of medical hindsight stemming in part from the interpretative angle conferred on a narrative viewed from a vantage point in the future. However, in medical histories fictitious threads are also not unknown; clinical stories are assembled from imperfect processes of perception, memory and personal censorship and are subject to ambiguity and distortion, perhaps from embarrassment, guilt or misunderstanding.

Whereas all the elements in a novel possess some meaning stemming from deliberate inclusion within the story, those in a life story may not.[23] Many of the experiences patients relate to their doctors are probably not interpretable within a medical framework and reflect, instead, 'lived temporality,' a *status quo* of feelings and sensations unrelated to medical processes.

Personal time

Experience of duration is bound up with an awareness of change, with the span of changeable feelings, bodily sensations, and with the passing of events.[24] A sense of inner time connects ideas and memories of past experience with those of the present, linking knowledge of who we once were with whom we have become. 'Making sense of one's life as a story is … not an optional extra', writes the philosopher, Charles Taylor, 'for in order to have a sense of who we are, we have to have a notion of who we have become, and where we are going'.[25] Ill health disrupts assumptions of futurity, distorting time's subjective flow, [26] and our sense of self and personal identity which in part depend on the intactness of an inner story (the story of one's life) extending through time.[27]

The poet Brian Patten asks how long a life is, and surmises that a person lives many different lengths of time (Box 3).[28] As individuals, we age at a pace that is slowing down in relation to the sequence of stellar time (Box 4), and our sense of time's passing is affected by ill health, social circumstances, and by institutionalisation. Pain may blot out all past and future,[29] while uncertainty and grief can so empty the present of meaning that the flow of time seems suspended (Box 5).[30]

Conclusion

Time is a narrative organiser of events and experience. Setting out temporal relations is as central to general practice consulting as it

Box 5: Waiting and Time

'Recently, or was it years ago, my wife found a breast lump which turned out to be malignant. She's 36. Since then, time has become distorted, the objective measures of calendars and clocks becoming meaningless as appointments, results, operations, and treatments have approached and passed. Min utes, hours, and days have become prolonged and compressed … Six months have sped by … what about the waiting? What to say to each other at the start and end of each day when there is only one date, and time, and result on your minds? … as the end of active treatment looms, there is the hardest wait of all. Life is no longer measured in terms of 'expectancy' but rather in terms of 'survival'.[30]

is to storytelling; in both, time and change are existentially entwined. Paul Ricoeur — following in the tracks of a long line of philosophical investigation — evokes the mystery and complexity of temporal relationships when he writes that: '…time has no being since the future is not yet, the past no longer, and the present does not remain. And yet we do speak of time as having being. We say that things to come will be, that things past were, and that things present are passing away'.[31]

Marked by the movements of the heavens and the motion of clocks, titrated in schedules, timetables, appointments, and diaries, in growth charts, kick charts, temperature charts, and scans, time is embedded in our clinical representations. An important task for clinicians is to discern and to articulate temporal components of biological processes with subjective accounts of patients' experiences.[32]

A clinical tale almost always coexists (and co-evolves) alongside a set of cognate other narratives, depicting similar beginnings and different endings or different middles and the same endings. Whether Barbara J's blindness resulted from her personality and cultural background, which together prevented her adopting a diabetic diet, or whether it stemmed from a diet and lifestyle primarily determined by poverty, whether it was right not to offer her intensive insulin treatment which might have resulted in a better visual outcome — these are a few of the alternative stories which I pondered silently as I registered Barbara J blind. Such 'virtual' stories are not the hypothetical fictions of mere thought experiments but an inevitable accompaniment of clinical practice that seeks to shape for the better the temporal, biological, and narrative courses of human lives.

Brian Hurwitz

References

1. Kermode F. *The sense of ending*. Oxford: OUP, 1968: 44-45, 47.
2. UK Prospective Diabetes Study Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). *Lancet* 1998; **352:** 837-853.
3. Heidegger M. *Being and time*. Oxford: Blackwell, 2000.
4. Elias N. *Time: an essay*. Oxford: Blackwell, 1992.
5. UK Prospective Diabetes Study Group. Effect of intensive blood-glucose control with metformin in overweight patients with type 2 diabetes (UKPDS 34). *Lancet* 1998; **352:** 854-865.
6. UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. *BMJ* 1998; **317:** 703-713.
7. Canguilhem G. *On the normal and the pathological*. Dortrecht: Reidel Publishing Company 1978: 46.
8. Armstrong D. The temporal body. In: Cooter R, Pickstone J (eds). *Medicine in the 20th century*. Amsterdam: Harwood Academic Publishers, 2000: 247-259.
9. Aristotle. Physics IV II 219 b1. Quoted by Eco U Times. In: Lippincott K (ed). *The story of time*. London: Merrell Holberton, 2000: 10-15.
10. Leach ER. *Rethinking anthropology*. London: LSE Monographs, 1971: 132-133.
11. Quoted in: King LS. *Medical thinking*. Princeton: Princeton University Press, 1992: 78.
12. Hurwitz B. Narrative and the practice of medicine. *Lancet* 2000; **356:** 2086-2089.
13. Greenhalgh T, Hurwitz B. Why study narrative? In: Greenhalgh T, Hurwitz B (eds). *Narrative based medicine*. London: BMJ Books, 1998: 3-16.
14. MacIntyre A. *After virtue: a study in moral theory*. London: Duckworth, 1981: 201.
15. Damasio A. *The feeling of what happens*. London: Vintage, 2000: 168.
16. Said EW. *Beginnings: intention and method*. New York: Columbia University Press, 1985: 4-5, 11.
17. Rimmon-Kenan S. *Narrative fiction: contemporary poetics*. London: Routledge, 1983: 6-17.
18. Hunter KM. *Doctors' stories*. Princeton: Princeton University Press, 1991.
19. Marinker M. The chameleon, the Judas goat and the cuckoo. *J R Coll Gen Pract* 1978; **28:** 199-206.
20. Amis M. *Time's arrow*. London: Penguin, 1991.
21. Bradbury M. *To the hermitage*. London: Picador, 2000: xxi.
22. Lamarque P. Narrative and invention: the limits of fictionality. In: Nash C (ed). *Narrative in culture*. London: Routledge, 1994: 172-198.
23. Bell M. How primordial is narrative? In: Nash C (ed). *Narrative in culture*. London: Routledge, 1994: 172-198.
24. Fraise P. *The psychology of time*. London: Eyre and Spottiswoode, 1963: 209.
25. Taylor C. *Sources of the self*. Cambridge: Cambridge University Press, 1989: 47-49.
26. Davies ML. Shattered assumptions: time and the experience of long-term HIV positivity. *Soc Sci Med* 1997; **44:** 561-571.
27. Orona C. Temporality and identity loss due to Alzheimer's disease. *Soc Sci Med* 1990; **30:** 1247-1256.
28. Patten B. So Many different Lengths of Time. In: *'Armada'*. London: Flamingo, 1996: 70-71.
29. Scarry E. *The body in pain*. Oxford: OUP, 1985.
30. McLeary G. Waiting with time. *BMJ* 2000; **321:** 940.
31. Ricoeur P. *Time and narrative*. Chicago: University of Chicago Press, 1984: 7.
32. Good MJD and Good BJ. Clinical narratives and the study of contemporary doctor-patient relationships. In: Albrecht GL, Fitzpatrick R and Scrimshaw SC (ed). *Handbook of social studies in health and medicine*. London: Sage, 2000: 246.

in brief...

I have a friend in Vienna who used to work as an editorial registrar at the *BMJ*. After more than two glasses of wine he would start dribbling on wistfully about the perfection and, well, Beauty, of the Randomised Control Trial, and the home of the most perfect, the most beautiful RCTs, namely the *New England Journal of Medicine*.

Oh dear. The sort of thing that Liam Farrell would reverse over to ensure that it was dead.

But, join with me, Gentle Sceptics, and inspect 'Intravenous zoledronic acid in postmenopausal women with low bone mineral density' (*N Engl J Med* 2002; **346:** 653-661). An elegant study comparing daily and weekly intake of our standard biphosphonate (alendronate), against the newer (unlicensed) agent given as three-, six- and 12-monthly IV infusions, against placebo. The numbers are big enough to merit significance. The Message (to be reproduced, generalised, and ensured safe) is that an annual five-minute IV infusion of 20 ml can do the same as horrid daily or weekly tablet taking.

The results are beautifully graphed — placebo plods along the horizontal axis, and the intervention groups arc cheerfully upwards, in tandem.

All rather elegant, in a Viennese sort of way.

Like the **Millennium Bridge**, now open, and not wobbling, a chance to walk directly from St Paul's across the Thames, for the first time ever. With **Tate Modern** at the other end of the bridge.

And hence, via **Southwark underground station**, and the **Royal Academy** (*Paris 1900–1968*), to the **Science Museum**, where, at present, scientists, engineers and artists try to cosy up with each other. In ***Head On: Art with the Brain in Mind*** neuroscience claims aesthetic credibility. At times with some success. Similarly, automobile engineers claim artistry, in a century's worth of Alfa Romeos — ***Sustaining Beauty: 90 Years of Art in Engineering***.

So what should we drive? An RCT, a Brain, or an Alfa Romeo?

Alec Logan

The Pursuit of Oblivion: a global history of narcotics, 1500–2000
Richard Davenport-Hines
Weidenfeld and Nicolson, 2001
HB, 448 pp, £20.00, 0 29764375 4

The Science of Marijuana
Leslie Iverson and Solomon H Snyder
2000, Oxford University Press Inc, USA
HB, 302pp, £19.95, 0 19513123 1

SOME books, events and people appear to change society. Do they truly, or did the individuals, authors, and participants conform to a change in the moral wind, feeling it on their cheek before others and turning in the right direction at the right time?

This book comes into that grouping. It will certainly change thinking and, hopefully, practice — but that might happen anyway. Here, however, is a reasoned description of the history of addiction in Western society and how we have got to our current situation of a war on drugs, probably unwinnable, through a combination of individual idealism, career advancement, and bad science, where an American ethos which didn't learn from Prohibition in the 1920s comes up against a more liberal European attitude.

'Every kind of addiction is bad, no matter whether the drug be alcohol, morphine or Idealism'.

Carl Jung

The book is a description of five centuries of addiction, and therefore emotional extremes, involving all classes and sorts of people. The historical evolution of substance usage as part of social behaviour to substance abuse in a criminalised system is charted. It describes how prohibition policies have turned legal but dangerous medicines into the world's biggest and most lucrative black market, worth $400 billion annually — 8% of world trade and the equivalent of the amount spent on tourism or the oil industry. The risks of the entrepreneur are extremely well rewarded. In Britain, heroin and morphine pastilles were available and included in packages sent to the troops in Flanders by wives, friends, and family. We had a reasonably effective model in the UK of dealing with addiction until the 1960s, when we adopted the punitive American model which we would now appear to be turning away from, with relaxation on possession of cannabis and official advice on how to manage raves.

Drugs are ubiquitous; intoxication is not unnatural or deviant.

The process whereby we have criminalised the user rather than regulating the substance has left us with prisons full of users, massive amounts of energy spent on detection and the treatment of associated pathology in the form of HIV, hepatitis, and sepsis.

In The Netherlands, after the opening of the coffee shops which came into being in 1978, there is now virtually no solvent abuse and the use of cannabis actually fell. Heroin usage is lower than in Britain or France and the junkie population is ageing, with fewer new recruits as a result of separating cannabis from heroin supply.

Contrast this with the Michael Forsyth apocalyptic vision and prohibitionist message of Scotland Against Drugs and then read the results in *Trainspotting*.

As Orwell said, all forms of recreation are attempts to escape reality. We would benefit from education and regulation, not punishment. The war against drugs is a chimera.

A memorable book, well thought through and closely argued. I am a convert, but then again I sense a change in the direction of the wind.

The Science of Marijuana is a dense, tightly packed, chocolate brownie of a book and a correspondingly concentrated review. The book summarises the historical background of marijuana use and details its known pharmacology with interesting reference to the naturally occurring cannabinoids. The medical usage of marijuana is reviewed and found to be wanting in hard data, other than in the areas of AIDS wasting syndrome and as an antiemetic in chemotherapy. Multiple sclerosis, muscular spasm, epilepsy, glaucoma, and asthma are areas of interest but require more research.

The safety of cannabis, now the world's third most popular recreational drug after tobacco and alcohol, is reviewed objectively and sensibly, a view based on extrapolation of existing usage. It is safer than President Bush believes; however, smoking increasing amounts will raise lung cancer and chronic obstructive pulminary disease rates by up to 10%, users will become dependent, and more road traffic accidents will result.

The book finishes with a look into the future and predicts that communities will demand a change of politicians who strike tough-jawed prohibitionist postures as a way of demonstrating their leadership qualities. The Dutch experience of grudging acceptance rather than full-blown marketing of marijuana in Tesco, seems a likely way forward.

A cool, perceptive, well structured, short reference book.

Gordon S D Peterkin

The Constant Gardener
John le Carré
Hodder and Stoughton, 2001
PB, 570pp, £6.99 (0 34073339 X)

I'VE never liked le Carré. All the macho cloak and dagger stuff always struck me as juvenile and terminally competitive. We GPs are supposed to be cuddly, caring, and facilitative. In the words of Kant, to 'so act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means',[1] It's a shame the Cold War always sold better than Kant.

So what is a jobbing author like le Carré to do after the fall of the Berlin wall? What Theatre of Blood is to be found between PoMo and Post 9/11? Who are the bad guys now? It was le Carré's brazen leap of seeing the pharmaceutical industry come whooping over the ridge as John Wayne circled the wagons that made me buy this book. Still le Carré, still paranoid, still the mixed up goodies seeking to outsmart the black-hearted baddies, still the beautiful and talented female corpse in chapter one that takes us the rest of the book to comprehend. So it's the usual Pharma-does-research-on-Africans-and-kills-to-cover-up-the-side-effects plot. And guess what — the flawed hero has to make tough choices between his integrity and his life. OK, you are buying a stereotype, but, just like Homer Simpson, a rather good one.

But consider the symbol behind the stereotype. The pharmaceutical industry is the embodiment of our culture's passionate but ambiguous relationship with science. Kill or cure, Jekyll or Hyde, Frankenfurter or Frankenstein? How uneasily we recognise our own faults and secrets and triumphs in the mirror of the Pharma companies. Best to burn the monster quickly, lest he turn and we see our own face.

Let me get cuddly again and plead for arbitration. In the 21st century, global industries have indeed become monstrous. But how eager we are to hunt down someone else's Id with all the righteous anger of our own Super-ego. People make the rules that industries play by. We're people too. We too can see others as either means or as ends depending on who's looking. Screaming at the monster won't make him play nice. Frankenstein's monster was only able to engage constructively with those ingenuous enough not to label him. We all have a bit of growing up to do.

Overall I still prefer Kant. But I'll admit le Carré writes a better thriller.

David Misselbrook

Reference

1. Kant I. *Groundwork of the metaphysics of morals.* [Translated by Gregor M.] Cambridge: Cambridge University Press, 1997; 38.

roger neighbour - behind the lines

Hypocrisy

IN February's Back Pages, I denounced as a breach of confidentiality the use by Scottish shepherds of blue paint to track the copulatory contacts between male sheep, or tups, and their lady flock-mates. The column prompted the following letter from a retired farmer in the Brecon Beacons.

'Sir,' he wrote, 'I beg to inform you that I found your article about tups to be Not At All Funny, and was the cause of words between myself and my lady wife, née Tupp. It has been my pleasure these many years to refer by jocularity to her brother the Reverend Gareth as 'the tup-hog' and to Evan his first-born, our nephew, as 'the tup-lamb'. Even (may God forgive me due to stress) that barren ewe who is the wife's mother I call her 'the tup-yeld'. Your tip about the blue paint put me in mind of some malarkey to enliven the Tupperware parties to which my lady wife is much given, and am pending litigation …'

No, I have to come clean. I had no such letter. It was make-believe — but invented for a reason I wish, gentle Reader, to confess to you.

On receiving my manuscript for the 'blue-bottomed sheep' piece, Alec the Deputy Editor had, (rather unfairly, I thought, he being a native Scot) queried my use of the word 'tup' on physiological grounds. He claimed that a toop, tuip or teep (as he variously spelt it, Scots being a no-go zone for the spell-check facility) had been castrated, and was therefore unable to rise to the occasion in the manner described. The Concise Scots Dictionary (Aberdeen University Press, page 740) put him right, however; and Alec, gentleman that he is, pledged me a bottle of champagne if I incorporated into my next column a specified selection of shepherding patois such as 'toop', 'tup-yeld' — I leave you to spot the others.

Well they're all there, Alec. Put that in your tup-horn and blow it; I and my empty glass await our reward.

Nevertheless, the exercise has confronted me with the price of my own honour. If it comes to a choice between prostituting my art as a columnist and a bottle of Krug '45, then it seems I'm for prostitution. It's worse than that: in February's piece I was chastising our profession for its willingness to play Government's silly games for money, and now here am.

OK, I am a hypocrite.

It's part of being human sometimes to do good things, and sometimes bad; and to do them sometimes for good reasons, and sometimes for bad. To do good things for good reasons is the business of saints or lovers, and relatively rare. To do bad things for bad reasons is also rare, rarer than the sanctimonious would have us believe. But most people lead their moral lives sloshing around in the middle, doing good things for bad reasons and bad things for good ones. We can — if we call it anything at all other than normal — call this paradox 'the human condition' to make ourselves feel better, but it's a passing fair definition of hypocrisy nonetheless.

One function of civilisation, it seems to me, is to contain our hypocrisies within an acceptable frame. The great professions exist to champion our greatest visions of what is good — health, wealth, justice, knowledge and security, while at the same time keeping our bad reasons for pursuing them — exploitation, greed, and self-aggrandisement, within bounds.

That's a heavy responsibility, I reckon, to lay on the shoulders of any profession comprised of mortals, even, as in our own case, of medically qualified mortals. I suspect the only way individual professionals like you and me can cope with it is by allowing the big paradox, the big hypocrisy, the big inconsistencies to trickle down until, acceptably diluted, they seep all but imperceptibly into the fibre and fabric of our everyday practice. Hypocrisy on the small scale is our stock-in-trade. We believe in continuity of care until the telephone rings at 3.00 am, and in personal doctoring until we go on a mid-week conference. Prescribing an antibiotic for a URTI doesn't seem as bad in a five-minute appointment as in a ten-minute one. Even our much-vaunted 'patient-centred consulting' can swiftly degenerate into simulation, a mere going through the motions of a *caritas* we often do not feel, yet dare not deny.

As grease in the professional workings, maybe a bit of judicious hypocrisy is no bad thing. If there was a vaccine against double standards, I doubt many doctors would have it.

So what sort of hypocrite has Alec's champagne trick shown me to be? A dyed-in-the-wool one, I guess. Am I alone?

American Sublime - Landscape Painting in the US 1820–1880
Tate Britain until 19 May 2002

It was with real excitement that I visited this show. Ever since Robert Hughes' 'American Visions', I have been fascinated by the epic painters of the 19th century American West, and the works of men like Church and Bierstadt are some of the most thrilling paintings I have seen. These works can be vast (as much as three metres by four metres), and they may really convince you that, as the Old World has its manmade marvels, so the New World is home to the grandest works of God.

The show begins with Thomas Cole, and his extraordinary series, 'The Course of Empire', an unquestioned highlight. While this commentary on both the British Empire (Cole was born in Bolton, Lancashire) and on the frenzied atmosphere in the US during Andrew Jackson's presidency is widely reproduced, it is not often seen, unless you can track down the New York Historical Society's premises the next time you are in Manhattan. This series was enormously influential, but Cole nonetheless had only one pupil, Frederick Church: it is a pity that the work of Cole which most clearly shows his influence on Church ('The Oxbow') is not here. Church himself is pretty well represented and his paintings of the West and of the Andes are the other great draw, although the finest piece shown here is in fact of icebergs — rightly set in a room on its own, and especially well framed and lit.

As well as the epic tradition of Cole and Church, the other main theme is the work of the Hudson Valley School, who concentrated largely (but not entirely) on marine painting. These paintings are exceptionally beautiful, and the quality of the light, especially in the works of Fitz Hugh Lane, is quite wonderful. However, they do not sit comfortably with Church and his fellows, and it is simply too much to take in to go from a room of vast paintings of volcanic eruptions to one of small, still seascapes. Only the sometimes sinister paintings of Martin Johnson Head offer that sense of the awesome which is a key part of the meaning of 'sublime', which otherwise is a little lost from view.

My greatest regret, however, is that the most magnificent works of the true 'American Sublime' are not here, for whatever reason: Church's 'Grand Canyon of the Yellowstone' (National Museum of American Art) and 'Niagara Falls', and Bierstadt's 'Last Buffalo' (both in the Corcoran Gallery) are the most thrilling of all their paintings, and they remain in Washington. I truly hope that seeing some of the work of Church and Bierstadt in particular will inspire you to look these up if you get to Washington, and this is the best reason for going to the show. Some American paintings of the 19th century (even with the exclusion of its greatest exponent, Winslow Homer) can almost rival Turner (and comfortably outclass the ghastly Constable), and they are too little seen in the UK. I urge you to take this rare opportunity.

Frank Minns

Thomas Moran (1837-1926). *The Grand Canyon of the Colorado* 1892 (reworked 1906). Oil on canvas, 1346.2 × 2388 mm.

Philadelphia Museum of Art, gift of Graeme Lorimer, 1975. Photo: Graydon Wood, 1993.

neville goodman

Dress

WHEN I was a final year medical student … I'm sorry, I know it's a cliché, but it sets the scene. In 1974 the consultants were upset because a female house officer starting coming to work wearing trousers. Last week, one of our female house officers was wearing a fairly tight black skirt with a slit to half way up the thigh. I found it very attractive, but I don't think it's right on a hospital ward. Am I just turning into an old-fashioned fuddy-duddy?

I could go onto the ward and ask the patients. Things have, after all, changed a lot in 25 years. The only people who matter on questions of doctors' dress are the patients. I used to put on jacket and tie when I went into the hospital on Sunday to see patients for my Monday list. If I hadn't done, many patients would have been uneasy, or at least surprised. Now, I make sure I'm clean and tidy, and I don't wear scruffy clothes, but I'll wear jeans if I happen to be wearing them anyway. I've not noticed that patients look askance when I introduce myself as, 'Dr Goodman, the anaesthetist for tomorrow.'

But there must be a limit somewhere. What if a doctor turned up in a black rubber dress, studded spiked neck choker, and six-inch red stiletto heels? Is there anyone who would defend that? It's only a matter of degree that brings us to consider a slit skirt. As I'm not going to ask her patients, I'll just give my opinion: which is that I do not think it is appropriate.

I didn't ask the consultants in 1974 why they objected to women doctors in trousers. They were workaday trousers; there was absolutely nothing sexy about them. I suspect the objection was that it wasn't 'done', or 'feminine', or that 'only lesbians wear trousers'. My objection to the slit skirt is that it is suggestively sexy, but maybe the patients don't notice. Maybe the women think it's nice having an attractive doctor who dresses well, and maybe the men (in the nicest sense) think the same.

But, whatever the aesthetics, a tight skirt isn't practical. The reason the house officer wore trousers in 1974 was for ease of movement, and so she didn't have to worry about sitting down or about flashing her knickers when running to a cardiac arrest. What with her not inconsiderable heels, any worthwhile attempt by today's house officer to reach the patient before rigor mortis sets in would be likely to see her in casualty with a sprained ankle.

Nev.W.Goodman@bris.ac.uk

our contributors

Searching for **Neville Goodman** via Google reveals a disappointing 8100 entries which will multiply quite soon when back issues of the *BJGP* appear on line, and not before time. Yes, *e*BJGP cometh ...
Nev.W.Goodman@bris.ac.uk

Brian Hurwitz is professor of medicine and the arts, King's College, London, but remains a practising GP

Eileen Hutton is chairman of the Patients' Liaiason Group of the RCGP
eileen@huttonhome.swinternet.co.uk

Frank Minns, RN Rtd, is now something very sleek in the City
frank.minns@cgey.com

David Misselbrook is a GP in Catford, south east London. He is the author of the very well received *Thinking about patients* (Petroc Press, 2001)
dpm@doctors.org.uk

Again using Google, readers should enter **Roger**, **Neighbour**, **Champagne** and **Sheep** and enjoy the consequences

Gordon Peterkin was formerly a GP in Forfar, he is now medical director of Grampian Healthcare
gordon.peterkin@ghc.grampian.scot.nhs.uk

Derelie Richards is a lecturer in general practice at the Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, University of Otago, New Zealand

Simon Tickle is a GP at the Maple Access Practice in Northampton
simon@totalise.co.uk

Les Toop is professor of general practice in Christchurch, New Zealand. He recommends possum fur-lined nipple warmers for chilly outdoor pursuits.
les.toop@chmeds.ac.nz ...

Useful advice for...
James Willis who has now written for the Back Pages of the *BJGP* more than 20 times and therefore qualifies for an all expenses paid trip to Barra Head. All expenses paid by James himself, of course. No Pharma corruption at *this* end of the Journal! Buy the book at
www.friendsinlowplaces.co.uk

All of our contributors can be contacted via the Journal office at journal@rcgp.org.uk

james willis

Wise after the event

HERE is a medical story in which the truth is pure and the ending simple. Such stories do occasionally occur. It involves my parents-in-law, who live in sheltered accommodation in the town, five minutes away by car.

On the morning in question my wife, with her uncanny prescience, knew that the early telephone call would be for her, so she answered the phone. Her mother was on the floor, again, and her father, again, couldn't get her up. After mooting some feeble alternatives, in a way I deeply understood, she got dressed and went down to help. Three-quarters of an hour later it was her on the phone, bringing me up to date. She had arrived to find the nice warden, who had also been called, explaining that she wasn't allowed to lift. So my wife, reckless free spirit that she is, had done the lifting and got her mother back to bed. Shaken and with a nasty bruise over one eye, but otherwise apparently OK. Did I think we should call the doctor?

Difficult, isn't it, but I said no, leave her in bed and I'll go myself and check her later in the morning.

So there I was, at about 11.00 am, doing my bit. Checking the bruise and getting her to stand out of bed, I launched jovially into my 'take up thy bed and walk' routine that used to earn me favour and dislike in equal measure in a hundred home counties households. I soon left her in the sitting room with my father-in-law, happy and relieved. Later in the day we called back, and as we finally left I put a smug mental tick against my management. One emergency call, perhaps one admission, saved. And no-one would ever know, blind as NHS performance indicators inevitably are to this kind of noble act.

Four days later my mother-in-law let slip in conversation that since her fall she hadn't been able to read.

She had had a stroke before, and of course that could have been the cause of the fall. Or the fall might have caused a stroke. I thought about the practicalities of treatment, a week after the event. Above all, I'm ashamed to say, I thought about my various categories of stupidity. I decided to keep out of it as she and my wife decided it would be best to see the optician.

Two days later, in an emergency slot, the optician was checking her eyes. After a bit he frowned and asked to see her glasses. He looked at the heavy frames and thick lenses and asked 'Where did you get these from?' I promised you a simple ending; she was wearing her husband's glasses.

It's a funny story, now, and I can tell it in a light-hearted way. It is also a story which is on the edge of what is reasonable to make public. But it wasn't a professional relationship and all the parties are happy that I should share it, so here is its point:

Now that the outcome is known I think you will agree that my advice and actions seem reasonable once again, even admirable. But during the interval, while a new development was suggesting a much more serious situation, or more likely a permanent uncertainty about what had happened, then I think it was equally clear to all of us that I had committed a serious error.

But the facts of the case were exactly the same. I mean, the situation at the time was the same. Common justice suggests that we should always judge ourselves according to the appearances and our intentions at the time we performed an action in question. For instance, the incompetent murderer who aims and misses is arguably more culpable than the crack-shot who pulls it off. But the law doesn't see it that way. In the practical world interpretation is irredeemably dependent on outcome.

This is another reason why medical practice is so much more difficult than appears from the outside and in retrospect.