

The Back Pages

viewpoint

Time to reverse that altruism bypass ...

ANOTHER Monday morning and I'm banging on to bored partners about the iniquity of pharma-sponsored coffee mugs, when an especially bored partner, obviously convalescing from a recent altruism bypass, takes issue — 'Why should GPs be any different from anyone else? Everyone's at it! Actuaries, bankers, solicitors. Back-handers, freebies, free holidays! What's the odd pharma-sponsored Biro in a corrupt universe?'

What indeed? At least two patients recently contacted our practice asking why they're on unromantic beta blockade for hypertension, as opposed to the new King of the Hill, losartan. They'd been reading the national press, filled with news of the LIFE studies, in advance (naturally) of publication in the *Lancet* on March 23.^{1,2} The lay press were wobbly at the knees.³ The GP comics almost similarly enthused: 'New studies show (losartan) is more effective at reducing cardiovascular complications and death than conventional first-line antihypertensive treatment'.⁴ Even the *Lancet*'s editorialists could barely contain their excitement: 'Angiotensin blockade ... a promise fulfilled'.⁵ Aaahh!

The LIFE papers are worth looking at carefully. Large, well-designed studies comparing patients with hypertension (+/- diabetes) on two regimens — thiazide plus atenolol versus thiazide plus losartan. Composite endpoints, at five years, CVS mortality, cerebrovascular accident, and myocardial infarction. Headline result — 25% reduction in MIs (and especially strokes) in the losartan group. Drop-out rates lower in the losartan arm, losartan better tolerated, etc. Guidelines to be adjusted ...

Game, set and match? Time to embark on wholesale angiotensin receptor blockade (ARB) instead of, or in addition to, beta blockade?

Well, maybe not just yet. Consider the following. The 9000-plus participants in the study had more than modest degrees of hypertension. Primary hypertension (160/200/95/115 mm Hg) with ECG evidence of left ventricular hypertrophy. Measurements of absolute risk reveal smaller numbers: 24 events per 1000 patient years in the losartan group against 28 per 1000 patient years in the atenolol group, i.e. only four fewer events per 1000 patient years. A majority of patients in both arms of the study ended on high(ish) doses of the agents, atenolol 100 mg, and losartan 100 mg daily. Hardly the standard dose, muddying comment on side effects. And losartan 100 mg per day costs £70 per month, but no mention of cost-benefit analyses.

And in any case, why atenolol as comparator, and not ACE inhibitors? After all, any additional benefit from an ARB is likely to be a class effect, and ACE inhibition may be at least as effective in most circumstances and a lot cheaper. Why are ACE inhibitors, the wonder drugs of the 1990s, suddenly trashed? Because of the nuisance of side effects? Surely not — ACE inhibitors are generally very well tolerated. Or because enalapril is off-patent, and losartan on-patent? Answers on a postcard, perhaps, to MSD, who make both.

Anyway, the point here is that conflicts of interest abound. The trial in question was funded by manufacturers. The *Lancet*'s editorialists cheerfully confess that they're consultants to almost all the major pharmaceutical companies that are active in the cardiovascular area. They have received funding for studies, seminars, and travel from such companies. This is not their fault, nor the *Lancet*'s. Finding a cardiologist who hasn't sipped at the well of pharma cannot be easy. If research funding originates from pharma by default, because no-one else, least of all the UK taxpayer, is prepared to foot the bill, then one cannot complain when researchers are uncomfortably close to the subject of their research.

It is however a powerful reason why we as GPs, self-styled guardians of patient interest, should zealously guard our independence. We don't need free lunches, nor a round at Turnberry. We shouldn't need sponsorship to fund professional development, clinical decision support software, audit, or clinical governance. Our patients know this.

And we should buy our own mugs.

Alec Logan

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"The CFS/ME compromise reflects a surrender of medical authority to consumer demand and popular prejudice. When Professor Donaldson claims that CFS/ME should be classified together with conditions such as multiple sclerosis and motor neurone disease, he sanctions irrationality ..."

ME — the dangers of Cartesian Fundamentalism
Michael Fitzpatrick, page 432

"... the young murdered princes play upon this climbing frame, now he is totally at their mercy. He rises a broken figure ... smaller in stature, prey to his doubts ..."

Jill Thistlethwaite on Kenneth Branagh, as Richard III, page 435

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THE Midland Faculty really had a tough challenge. They had to provide a worthwhile College Spring Meeting, delivered in not much more than half a day. And this wasn't just any Spring Meeting, but the one marking the College's 50th anniversary.

To succeed at all is worthy of praise. They succeeded well, by an impeccable venue, and a carefully selected group of speakers who delivered addresses of insight and clarity. That being said, three demanding lectures in a morning, punctuated by a single coffee break, left me with a sort of intellectual dyspepsia. And that doesn't include Jacky Hayden's Pickles Lecture on the Saturday afternoon. I felt that I needed a bit more time to take in the messages, to work through some of the ideas in group work, to let my head stop spinning. But this was the essence of the constraints they had, and it worked within its limits.

Postcard from Kuala Lumpur

The WONCA Asia Pacific Regional Conference (31 March to 4 April 2002) offered rich and varied experiences to the participants. This is a diverse region, not least in the roles of family physicians in health care.

Highlights? Wes Fabb from Australia, inaugurating his own oration. He has consistently promoted high standards of family medicine, education, and practice around the world. Subsequent awardees will be chosen from family physicians in Asia Pacific who have made significant contributions to family medicine development. Also, the launch of *Asia Pacific Family Medicine*, a new journal dedicated to promoting the discipline of family medicine within the region, providing practical and relevant articles for all family doctors. It will also disseminate high quality regional research and enhance standards of family medicine by focusing on best practice.

The breadth of the region encompasses much cultural diversity, which provides a rich and complex heritage. The first issue reflects this diversity, and also focuses on families—a strong force and ally in health care.

Conferences bring forward take-home messages for participants. The first message here reminded us that health and ill health are multifactorial. Interventions must be comprehensive, tackling not only clinical issues but the psychosocial as well. Family medicine, as well as dealing with acute illness, also encompasses prevention, chronic care, and palliative care. However, the realisation that self-care is part of the spectrum is a challenge for family doctors. If patients have unmet needs then doctors also have unmet education needs, which can be addressed by self-directed activities and personal development plans.

Lastly, formulation of lifelong health plans for families is a possibility for the future. Thus family doctors are not only healers but counsellors, educators of patients, lifelong learners, researchers, and social mobilisers.

Indarjit Singh, possibly the best known Sikh in Britain (at least to listeners of Radio 4's *Today* programme) opened with a reflection on creeping personal and social selfishness. He issued a particular challenge to the unreflected acquisitiveness of the few for modest improvements in health, purchased at high cost. This he contrasted with the large health improvements possible for the many in our society, particularly poor children, purchasable at modest cost. In my view, Singh is at his best in the three-minute format of Thought for the Day. The more extended presentation, valuable though it certainly was, didn't gain from the greater length.

James Willis' discussion of science was richer meat by far. He spoke of our professional imperative to clearly illustrate the hazards between Scylla, the two-headed monster of anti-science and pseudo-science, and Charybdis, the bottomless whirlpool of the fake certainties of political reductionism.

Ultimately, reality cannot adequately be addressed in digital format. The complexity of real life renders all judgements and descriptions provisional and hedged with uncertainties, even within their own terms. Care doesn't come pre-packaged in numerically measurable units.

A world of right decisions, in which risk can be eradicated and error must constantly be identified and rooted out in a futile pursuit of certain safety, is a dangerous deception. This travesty presents in many forms, constantly mutating. I am reminded more of the many-headed Hydra than Willis's analogy of the whirlpool Charybdis. Whichever mythic peril is most pertinent, the challenge to our scientific profession is uncompromising, whether this challenge arises from the false promises of pseudo-medicine or from the reductionist certainties of policy-makers. The false prophets must be exposed and denied.

David Pendleton completed the cycle of talks with a review of the College's last 50 years, and a challenge for the next. In response to the meltdown in medical morale, the College is challenged:

- to respond with renewed clarity in its mission, vision and values;
- to rebuild trust between patients and doctors, generalists and specialists, professionals and policy implementers, trust which is constructed on competence, care, consistency and courage; and
- to commit to leadership that provides inspiration, is focused in action, enables excellence, rewards achievement, and values learning over blame.

Faced with apparent duplicity, or at least ignorance, from those who rule over us, it can be difficult to maintain a commitment to action and trust. For this, the final word must go to Professor Sir Michael Drury, who produced a pastiche of Kipling at the Golden Anniversary dinner on Friday night, a portion of which follows:

*If you can keep your head when all around you,
The Service that you work in changes day by day,
If you can stand whilst all the problems that confound you,
Remain the same in spite of what the politicians say,
If you can trust your patients and by them be trusted,
When all the world is seeking one to blame
And for every fall resulting in a bone that's busted,
Some compensation is the object of a claim;
If you can use the high-tech medicine that's about you,
Yet not lose the individual patient in the strife.
If you can accept that individual's right to doubt you,
And not mock their different way of life,
If every ten years the knowledge that you sought for,
Is either wrong or simply out of date,
If all professional freedom that you fought for,
Is subject to interference from the State;
Remember what the College always stood for,
And when another fifty years are gone,
Who knows what people think that we were good for
Or which battles that we fought were lost or won.*

Zorayda Leopando

Joe Neary

THE joke among the graduate students in my programme used to be that the final question for our doctoral examination would probably be, 'So what exactly is the medical humanities, anyway?'

This same question was very much on the minds of attendees at *Healing Partners: Learning from Each Other*, at the Royal Society of Arts in London, sponsored by the Centre for Medical Humanities at the Royal Free and University College Medical School, this year in partnership with the Master Scholars Program of the New York University School of Medicine.

Over the two days of the conference, attended by about 145 people, the many perspectives of the medical humanities by academics, clinicians, policy makers, and arts practitioners were on full display. Presentations covered such diverse topics as curricular change in medical education; narrative writing by patients and health professionals; creative writing as a part of continuing professional development; art and post-genomic medicine; and health, human rights, and advocacy. Participants were challenged in plenary addresses, free papers, and workshops to consider the links, and the tensions, between the arts and the sciences, particularly as applied to health and medical environments. Michael Worton (Vice-Provost, University College London) warned the group to beware the dangers of well-intentioned dilettantism.

Some of the most energetic exchanges involved the question of evaluation, or how, or even whether, to measure the effects of exposure to the humanities. Is the randomised controlled trial, for example, an appropriate tool for work in the medical humanities? Underlying the discussion was a tacit acknowledgement of the challenges interdisciplinary work poses for evaluation.

Much conversation in the medical humanities seems inevitably to focus on defining its boundaries, figuring out what the term, and the field, or the discipline, or the practise, includes, and what is not properly within its purview. Given its inherent ambiguities (and, in the United Kingdom, its youth and newness), how should a curriculum, whether within the boundaries of medical education or beyond, be structured to best incorporate the values of the humanities? Should the focus be on undergraduates or graduates and trainees? Is the medical humanities primarily an area of scholarly inquiry, or not? Doubtless these questions and more like them will continue to be debated, at next year's conference, and perhaps for many more to come.

Faith McLellan

Believe me, public involvement does work – honest!

SOME of us are convinced that public or lay involvement in primary health care is valuable. Many colleagues remain unconvinced despite, or even because, it is a political imperative. In England, lay representation on Primary Care Groups has been compulsory for some time, and patient forums within Primary Care Trusts and PALS are now a reality. But will these organisational changes lead to the culture shift deemed necessary to make widespread meaningful public involvement a reality?

There are good reasons for the main focus of public involvement activity being set at Primary Care Organisation (PCO) level. A critical mass of the public is required to access representative populations and to achieve workable economies of scale. For instance, some practices, particularly smaller ones, might feel that the input required to learn how to do public involvement is a major disincentive. This need not be the case, because the crux of public involvement is that, no matter how simple, what works, works. As a relatively new field there is no single right way to do it. People are learning by doing. However, such a step into the unknown is not immediately attractive to hard-pressed primary care teams. Full-scale public participation in health care planning and delivery may be the gold standard of public involvement, but simplicity, such as just providing access to information, can be best. There follows a cautionary tale.

In 1999, the fledgling South Central Edinburgh Local Health Care Co-operative established a public consultation group with lay members drawn from local community councils and health projects. The group worked hard but ultimately foundered owing to lack of direction, increasing dysfunction, and difficulty in establishing effective reciprocal information flow. It was unable to input at a level where it could influence planning. It was tolerated rather than understood by professionals. In retrospect, its goals were never sufficiently clearly defined and there was a lack of both financial and human resource to follow up exciting new ideas.

Nevertheless, it was instrumental in enabling the LHCC to become one of the first in Scotland to develop its public involvement strategy. It developed a patients' quality agenda based on patients' perceived needs. The group also contributed to useful consultation with local voluntary agencies. Their need was found to be better dissemination of information about their activities through the community. This matched a need within the LHCC for better access to such information. Thus the group's major legacy has been the recent implementation of a patient accessible, regularly updated and updatable computer database, facilitating access to information on local resources. It has taken two years to bring the project to fruition, requiring much administrative input. The other rate-limiting factor has been the protracted search for funding. Ultimately, installation was funded mainly through residual fundholding savings and by a £1000 grant from the *Designed to Involve* project (SEHD, 1999).

Although so far this resource is only available in the premises of one local practice, the partners and staff have greeted it enthusiastically. A tangible result has been achieved in terms of care delivery and professionals are starting to see some benefit from public involvement. It also seems to be providing a focus for volunteer input, which is being co-ordinated by the LHCC's new Health Council-funded dedicated public involvement worker. She is already in danger of being swamped by new projects!

Many Scottish successes were described at the two-day conference in September 2001, concluding the *Designed to Involve* initiative. These included projects as diverse as small patient focus groups tackling well defined clinical areas and patient complaints, support groups, e.g. for women taking antidepressants in a small community, and a health outreach project for teenagers. Most demonstrated that the people involved perceived a definite health gain. Few were perfect and there were many learning points. Interestingly, consistent themes, similar to those arising from the Edinburgh project emerged repeatedly

- Tokenism is not productive.
- The goals of a public involvement initiative must be clearly defined.
- Any project should be geared to defined local needs and work to a bottom-up approach.
- An ethos of partnership working is crucial.
- Start simply and work towards an ultimate goal of full-scale public involvement.
- Public involvement must be given sufficient priority by PCOs to ensure resources.
- Adequate administrative support is essential.
- Prepare everyone for a potentially long lead-in time.

Consequently, results can be achieved. It is these results, particularly when they show benefit in terms of care delivery that will lead colleagues to accept that public involvement does work and then to embrace it.

Keith Donaldson
Catti Moss

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IMPORTANT changes in the delivery of primary care have occurred in the United Kingdom, through the introduction of consumerist principles. Walk-in centres in major cities provide patients with the opportunity to access a general practitioner at a convenient time and place, and it is hoped that advances in the use of computer technology will overcome potential problems that these changes may create with transfer of information between doctors.

Computers in general practice in the UK are currently used to manage patients appointments, in the storage and handling of information, and to help with disease management, recall, and audit. In 1998 the NHS Executive proposed that the health service should provide lifelong electronic health records for all, access to information about best practice, and integrated electronic systems incorporating GPs, hospitals, and community services.¹ However, there is still a long way to go to achieve the NHSE's objectives. The experience of other countries, for example Australia, can teach us valuable lessons, in particular, those orientated around consumerism and the role of IT in the delivery of primary care.

The history of GP computer use in the UK and Australia

In the UK, general practice computing started in the 1970s, with the Exeter project. By the early 1980s, GP computerisation had evolved to the extent that prescribing restrictions could be imposed, recall systems were the norm, and even interactive disease management protocols were being trialed.²

General practice computer systems have always been intended to be used to facilitate clinical care. However, with the introduction of fundholding in the late 1980s, their use was further enhanced as tools for the financial management of the practice and to access information through the newly evolving internet. More recently, many practices have further extended their use towards a paperless surgery. An agreement between the BMA and the Department of Health was reached in 1999 to change the regulations and legitimise this concept; the NHSnet has since become the largest private network of computers in Europe,³ with 99% of UK practices connected.

The Australian federal government also appreciated the importance of computerisation in general practice, offering incentives in the late 1990s through the practice incentive payments (PIPs) scheme. As an example, an additional

payment was awarded to practices where more than 60% of their prescriptions were electronically generated. More recent PIPs have been introduced to enhance continuity and to encourage preventative care.

Organisational differences in primary care

There are important differences in the structure of the health care systems within the two countries. In the UK, patients register with a single general practitioner; and the doctor becomes responsible for keeping the patient record. Inherent within the system is the tracking of the record from doctor to doctor as the patient moves through life, leading to enhanced continuity of care, the cradle to the grave philosophy.

In Australia, where there is a comprehensive belief in freedom of choice, patients may visit any primary care practitioner they wish, can get a second opinion from another doctor and move between doctors without transfer of records taking place. At its extreme, this can lead to the phenomenon of doctor shopping, where some patients move around doctors until they get the prescription or the advice they seek, and where continuity is non-existent. This problem is further compounded by extreme distances and geographical isolation.

Consequently, the Australian health service has had difficulties identifying a single point of access from which to administer disease prevention measures and this has resulted in low levels of vaccination and cervical cytology uptake. Being a problem essentially owing to the organisation of health care delivery, it is likely to respond only partially to federal government initiatives in primary care IT.

Australian general practice is fundamentally a service industry,⁴ particularly in the cities, where much of general practice concentrates upon the provision of acute care. This has been exacerbated by a system that rewards doctors for seeing as many patients as possible to maximise income. Until recently, there were few financial incentives to undertake chronic care management. While UK general practice also plays a major role in providing acute care, traditionally there has been a much greater emphasis on chronic disease and preventative health and this has been reflected in the way that computer systems have been used.

Comparing the use of computer systems
The systems in the UK and Australia have

much in common. Both are able to provide practitioners with access to development and risk charts, health improvement and assessment indices, patient/consumer information, and computer decision-support systems.

However, there are differences in the way in which computers are used in the two countries. In Australia, patients' expectations are to receive readily available information, related to treatments and investigations. The technology has been designed to accommodate these requirements. These facilities are available in many areas in the UK, but are less frequently used. Financial management also plays an important role in each consultation, and this is reflected in the layout of the screens and the data collected during the consultation.

Many practices in Australia have direct links to laboratory services. As an example, the authors are able to access most results for investigations within 24 hours of the specimen being collected, though some are processed in a laboratory over 700 kilometres from the practice.

Direct access to the internet in the consulting room has become more common in both the UK and Australia. Australian GPs are increasingly using this facility to obtain and read the most up-to-date e-journals and to search and retrieve health information for the patient in their presence, all of which further enhances the doctor-patient relationship. There have been discussions relating to the possible use of the internet for distant consultations,⁵ and already many rural practices are using dedicated video conferencing units for specialist services. This is important in a country where consultant support may be 1000 km distant and up to 38% of staff may use this facility, as in a recent study from rural South Australia.⁶ A good example is the reliance on this technology by rural psychiatric services.

In the UK, an increased emphasis on the collection of data during the consultation related to the needs of clinical algorithms required for chronic disease management and preventive care has dictated the manner in which computer systems are used,⁷ although for many years there has also been concerns about the possible negative effects of computer use on the doctor-patient relationship.^{8,9}

The UK Department of Health has

attempted to implement computer-based protocols through the introduction of a government-sponsored clinical decision support system: PRODIGY (Prescribing Rationally with Decision Support In General Practice).^{10,11} It provides advice on choice of medication and clinical recommendations for 200 clinical conditions common to general practice. The use of computer decision support systems in the consultation can lead to benefits in disease prevention and immunisation rates,¹² drug dosing,¹³ and the management of chronic illness.^{14,15} However, the consultation time is lengthened by their use and there is no appreciable impact on patient satisfaction,¹² both of which may limit the extent to which this type of system can be introduced into Australian consumer-orientated general practice.

Conclusion

General practitioners in the UK, in comparison with their Australian counterparts, have had a head start with regard to computerisation, but they can still learn from the Australian experience. A fee-for-service system that is orientated around consumer choice fails to address issues of continuity required for good chronic and preventative care. It is apparent to the authors that advances in computer technology and usage within general practice cannot compensate in full for deficiencies inherent within such a system as found in Australia, although little research has explored this question to date.

The Australian experience tells us that we should be careful about the way in which we introduce changes to health service delivery. The introduction of walk-in centres by the NHS is likely to improve satisfaction with the service in some groups but, unless carefully managed, may lead to reduced continuity and limit the extent to which preventive care and chronic disease management measures can be implemented.

In the UK, we should build on our strengths, including our registered lists, the provision of comprehensive primary care, continuity, and good long-term disease management. Computer systems can help general practitioners to achieve these goals, by managing large amounts of data effectively and allowing doctors to concentrate on patient care.

**Andrew Thornett
Alan Evans
Nigel Watson**

The Aussie consultation

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IN 1992, disillusioned by the NHS, I moved to country South Australia as a general practitioner. The challenge, I thought, would be one of establishing my reputation within the community and learning the business of medicine Australian style, a fee-for-service health delivery system based on patient choice and motivation.

The bureaucracy was relatively simple: just understand what had happened in the UK over the previous 15 years, Australianise it in complexity and nomenclature and you have it. Things have changed, not all for the better; the paperwork continues to snow the doctor under. But the consultation has been the biggest ongoing challenge to date.

To set the scene: every patient in Australia has the freedom of choice to see whichever GP they wish. There is no registered list, no individual contract for general medical services. All consultations are fee-for-service as is every conceivable item of care. We have a fine tome itemising all the services and the schedule fee (that which the federal government says it should be). The patient reimbursement from the State is based on an 85% of this schedule fee. Needless to say, the doctor can charge this fee, the AMA recommended or any figure. The nearest thing to a fully socialised service is when the patient assigns their reimbursement to be paid directly to the doctor (this is termed *bulkbilling*). The advantage to the patient is that it costs them nothing and the doctor has no apparent bad debts.

The system has some very subtle changes and influences on the consultation that only somebody who has worked in both systems would be sensitive to. I regularly perceive aspects of the consultation being modified

by these effects: the presentation of the problem, the history telling, the patient's expectations, sharing decision making and the immediate outcome; worse still are the long-term outcomes, the patient's understanding, and insight into their health and their responsibility.

Add to this the notions of The business of medicine and time costs/earns money and you have a very different consultation to the ideal according to Byrne and Long¹ all those years ago. For the basic consultation fees are based on time, content and systems examined, and whether the GP is vocationally registered or not.

The biggest influence on the structure and flow of the consultation is a historical and cultural one; the expectation of getting value for money. Frequently I receive requests with the intonation of a demand. I want is the oft-heard opening gambit to the consultation. Second and third opinions are asked for, as are unnecessary investigations and requests for medications. There is this an almost obsessional expectation; hence the request for blood pressure to be taken at every attendance.

Patients often have difficulty in formulating their reasons for the visit. They come poorly prepared. Thus history taking can become fragmented and you rarely see a list/aid memoir of what the patient wants to ask or say. The consultation disjointed, as the patient leaps from one issue to another, for they seem to have little notion of keeping to the point and the relevance of the aspect of the history that they are being questioned about. Frequently they want to deal with more than one thing at a time. I am sure this has evolved because in a fee-for-service situation there are not the same constraints on time and pressures, either actual or



Port Lincoln, South Australia.

perceived, as there is (or was) in the UK.

Over the past few years I have noticed a subtle change in my patients, that is one of taking responsibility for managing their illnesses. There is still a deeply entrenched concept that if they are ill it's the doctor's role to fix the patient up and get them better. As a part of this there is often a poor insight into the need for follow-up and continuity. On many occasions one can directly attribute this to economic factors. Likewise the frequent occurrence of getting prescriptions dispensed late, if at all. As a GP who works in a socioeconomically deprived area I have to be aware of what the patient can afford. Often they will have to make do with the second choice in medication or, worse still, go without.

Instant treatment and instant cures seem to be their desires. The concept of using time and just wait and see appears to be difficult for many patients to accept. Yet, unexpectedly allied to this there is an expectation for explanations and questions to be answered. However, active listening is a skill that few patients possess. More often than not it's listening to interrupt, and thus they will depart with little change in personal health knowledge. Consequently the long-term influence of the encounter is negligible.

The system encourages the notion of one-off medicine in both patient and doctor alike. By this I mean that every encounter is perceived as a separate disease entity. Those problems that are too complex or difficult are all too frequently ignored, and many patients know it. Consequently there is a considerable undertone of disrespect for the GP.

The bureaucracy also has an effect on the erosion into the already potentially fragile doctor-patient relationship—restrictions on prescribing, such as pack sizes, the number of repeat prescriptions, and specific requirements that have to be shown to have been adhered to before one is permitted to prescribe certain medications. All have cost consequences for both the doctor and the patient in time and money.

One has to be very much aware that in Australia this is a service industry and to survive as a doctor and maintain the ethos—medicine first and business second—one must tread a fine grey line. I make no bones about it; the direct payment for the service does increase my job satisfaction, if only in a pecuniary way, and assists in making those heartsink patients more tolerable, and I would not return to a capitation-based payment system.

Alan Evans

elizabeth rozario

Practising communication skills

So I passed the assumptive assessment, got to grips with communication skills, did the video elements, and passed the MRCGP exam. Carry on using these communication skills you now have learnt; they will come in useful wherever you are, my trainer advised me. So here I am, a fully-fledged, qualified GP, doing work for the Voluntary Services Organisation, in Vanuatu in the South Pacific!

The first problem I encountered was language. So much is lost in translation; the nurse interpreting for me gets the full story and all I get is a brief summary. I miss vital cues and most of the history. Easily sorted, I say to myself—let's master the language. Bislama is pidgin English and has not been too hard to get to grips with. So in the next consultation I try again on my own this time, and ask the question, but receive only a blank look. This old lady has lived in the village all her life and knows only her local language. Eventually a relative has to interpret for me. Patients can express themselves better in a language they are comfortable with, but this doctor has to concentrate hard to follow what they are saying. One thing I keep wondering about is, am I saying what I want to say and have I actually understood what the patient is telling me? I receive more blank looks when the patient cannot understand my Bislama because of my English accent.

So let us move on. What do you think is causing the problem? . I say. The big chief of Ambae died yesterday in the morning. His spirit was going around causing mischief and that is why my little boy's face is swelling up. Oh, okay. I was thinking it might have been an allergic reaction. Silly me. But I won't give up yet, so I ask the next patient the same question. The village elders prayed for my child. They found out the truth. Little Fred was not really playing with another child. It was actually a devil disguised as a child and it was the devil that put the seed in Fred's ear. Oh how stupid of me not to realise this; I thought it was something most kids do, put things in their ears or nose.

So, what about body language? How about eye contact? Forget it. Here it is discourteous to look superior in the eye. Use silence? Some of them are too shy or afraid to talk and are quite happy to sit there waiting for me to speak.

How about explaining the illness to the patient? You have kidney disease. How do I explain kidney when they have no concept of the body parts? It is a virus, so you don't need antibiotics. What on earth is a virus? Eat lots of fruit as they contain lots of vitamins. Vitamins stop you getting sick again. What is a vitamin? Even the nurses seem to struggle!

In short, I would like to apologise to my trainer and the examining board. Try as I might, practising communication skills is not easy overseas. It is more about learning about the culture and feeling comfortable talking in a different language first.

An earlier version of this article was published by the online magazine *Spiked* (www.spiked-online.com) in January 2002. A shortened form also appeared in *The Guardian* on 7 February 2002.

'The saga of chronic fatigue syndrome represents a kind of cautionary tale for those doctors who lose sight of the scientific underpinning of medicine, and for those patients who lose their good sense in the media-spawned "disease-of-the-month" clamour that poisons the doctor-patient relationship'.

Edward Shorter. From: *Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*, page 304.

MYALGIC encephalomyelitis (ME), also known as chronic fatigue syndrome, must be recognised as a genuine illness, according to a working group reporting to the Chief Medical Officer, Professor Sir Liam Donaldson.¹ This is a real disease affecting real people declared Professor Donaldson, enthusiastically endorsing the CFS/ME report.² Editorials in the *BMJ* and the *Lancet* gave qualified approval to the report.^{3,4} Both expressed some exasperation at the controversies that had dogged the working group, as they have numerous earlier attempts to forge a consensus in this field. In a strikingly identical phrase, both editorials insisted that, for clinicians, researchers and patient advocates alike, the time has come to move on .

Unfortunately, the aspiration to move forward is contradicted by a report which, on key aspects of the clinical difficulties presented by patients suffering from chronic fatigue and other unexplained physical symptoms projects a march into the past. The new official policy on ME is the result of a consensus that emerged following the exclusion of leading psychiatrists and other experts in this field. Endorsed by the CMO, this policy is now to be imposed on the medical profession as a whole. The dispute over how to name the condition is symbolic of the wider problem.

What's in a name?

The diagnosis of benign myalgic encephalomyelitis emerged in response to an epidemic of muscle pain and fatigue at the Royal Free Hospital in London in 1955. Though the term implies inflammation of the brain and spinal cord, no such pathology has ever been identified. In the early 1980s the term, abbreviated to ME came to be applied to sporadic, but increasingly numerous, cases of profound and prolonged fatigue, associated with muscle pain and malaise, and a wide range of other symptoms. Medical opinion shifted towards the term chronic fatigue syndrome, which emphasised the predominant symptom without making any assumptions about the cause of the condition or its pathology. A 1996 report by an earlier working group of the Royal Colleges of

Physicians, Psychiatrists and General Practitioners explicitly rejected the term ME on the grounds that it erroneously endorses the existence of a specific pathological process for which in the context there is no evidence .⁵

Organisations such as Action for ME and the ME Association, which are supported by some sufferers and their families and carers, repudiated the 1996 report. Their campaigning efforts pushed the Department of Health into setting up the working group that produced the new report. Many ME activists feel that the term fatigue, a familiar synonym for tiredness, fails to reflect the profundity of their symptoms. They also cling to the conviction that their symptoms are the result of some infectious agent or immunological disorder and thus favour a label which implies such an aetiology (though exhaustive researches have failed to confirm this). No doubt, like generations of doctors, some enjoy the legitimacy conferred by a polysyllabic Latinate term, even though perhaps because it mystifies rather than clarifies the underlying condition.

The report presents the adoption by the working group of the formula CFS/ME as a compromise between the medical preference for CFS and the patients groups preference for ME. The report proposes CFS/ME as an umbrella term, an approach it believes ensures as far as possible an inclusive approach. In reality, the approach reflected in this compromise ensured the inclusion of the ME lobby and the CMO and the exclusion of the broad body of medical and psychiatric opinion represented by the 1996 report (and reflected in the resignations of four leading clinicians from the current working group).

The CFS/ME compromise reflects a surrender of medical authority to consumer demand and popular prejudice. When Professor Donaldson claims that CFS/ME should be classified together with conditions such as multiple sclerosis and motor neurone disease, he sanctions irrationality. It seems perverse that ME activists should be reassured by the identification of their condition with diseases which are progressive and often fatal (neither of which is true for CFS/ME). Furthermore, both multiple sclerosis and motor neurone disease have distinctive clinical features and pathological processes which can be confirmed by investigations (neither of which is the case for CFS/ME).

A clash of models

The key clash on the CFS/ME working group was between proponents of two conflicting theories of the illness, designated in the report as the biomedical

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and the biopsychosocial models. From the biomedical perspective, CFS/ME is a condition like many other medical conditions where illness results from a specific pathological defect in physiological functioning, mediated at organ, tissue, cellular and/or molecular level, by as yet undefined mechanisms. The biopsychosocial model, by contrast, suggests that once an illness has started, its expression is affected by beliefs, coping styles, and behaviours, while consequential physiological and psychological effects act in some ways to maintain and/or modify the disease process.

The clash of perspectives came to a head over the question of therapeutic interventions. Following the conclusions of a recently published systematic review, proponents of the biopsychosocial approach argued that only two forms of treatment graded exercise therapy (GET) and cognitive behavioural therapy (CBT) have been shown to be effective and could therefore be recommended in the report.⁶ In opposition to this view, advocates of the biomedical model recommended the energy management strategy of pacing, which accepts that the best way for a patient to manage their illness is to try to live within the limits of their limited reserves of energy. This approach is appealing to ME activists, who hold that their disease may be exacerbated by GET. On the other hand, many clinicians fear that pacing could perpetuate the condition by encouraging prolonged and debilitating inactivity. It was the decision of the working group to endorse pacing (as well as GET and CBT) that led to the departure of most of the clinicians.⁷

Cartesian fundamentalism

Sufferers from CFS/ME and their advocacy groups cling to two convictions with a passionate and sometimes ferocious intensity. They fervently believe that their symptoms have an organic basis and they equally fervently repudiate any suggestion that these symptoms might have a psychological origin. The most popular explanations of CFS/ME are derived from immunology, a discipline which has won both scientific and popular prestige over the past two decades. It is now widely believed that individuals whose immune systems have been overloaded and weakened by the stresses of modern life are vulnerable to viral infections or other triggers of chronic fatigue states. Though this thesis cannot be sustained in the realm of science, it acts as a narrative device, a cultural explanation, and a method of linking mind and body that preserves self-esteem.⁸ Yet despite warnings that such explanations should not be taken as literal truth, but as metaphorical description, they have the status of divine

revelation among ME activists.

It is ironic that doctors, who are often accused of mechanically separating body from mind, find themselves defending a subtly dialectical conception against the Cartesian fundamentalists of the ME lobby. The much-criticised world of biomedicine has long acknowledged the role of the mind in producing symptoms in the body, with concepts such as somatisation and psychosomatic symptoms.⁹ In their dismissal of psychology and their fixation on the minutiae of immunology, the ME organisations endorse the dualism of mind and body from which modern medicine has been gradually emerging over the past 300 years.

By dogmatically repudiating any recognition of the role of psychological factors in the genesis of physical symptoms, ME advocates implicitly endorse the stigmatisation of mental illness. When they claim that ME is a genuine and real illness, they imply that symptoms for which no organic cause can be found are therefore false, fraudulent or imaginary.

Biopsychosocial

Anybody who criticises the biomedical model of ME is caricatured by its advocates as believing that ME does not exist or that it is all in the mind. But any doctor who has dealt with patients who complain of chronic fatigue knows that these physical symptoms and their debilitating consequences are all too real. Advocates of the biopsychosocial model have attempted to develop a way of understanding the symptoms of chronic fatigue that takes account of psychological as well as physical factors. Their approach to treatment is commonsensical rather than ideological, leaving aside controversies about aetiology and trying to discover practical interventions that can be shown to have some effect in alleviating symptoms.

From a historical perspective, the psychosomatic character of chronic fatigue is readily apparent.^{10,11} In his survey, Shorter notes that the volume of perceived aches, pains, and weariness changes little historically: what changes is people's readiness to seek medical help for these symptoms, to define them as diseases and to give them fixed attributions. In common with other historians, he is struck by the disappearance of classical hysteria in the early 20th century, and its gradual replacement by complaints about pain and fatigue.

Both the biomedical and the biopsychosocial approaches evade the role of social factors in the genesis of CFS/ME. Proponents of the biomedical model do this on principle because for them the biological

determination of the condition is a matter of faith. For advocates of the biopsychosocial approach, this is partly a pragmatic decision, to avoid further antagonising the ME lobby, and partly a result of the narrowly psychological focus of much work on CFS. Yet it is crucial to grasp the specific social and historical factors that have contributed to the emergence of CFS/ME since the 1980s if we are to achieve a deeper understanding of this condition and to devise more effective ways of helping its sufferers.

The dangers of medicalisation

The official endorsement of a biomedical model of CFS/ME reflects a wider tendency to deal with the problem of unexplained physical symptoms by redefining illness as disease.¹² Others complaining of symptoms for which no cause can be found are offered labels such as fibromyalgia, repetitive strain injury, irritable bowel syndrome, food allergy, or multiple chemical sensitivity. The proliferation of diagnostic categories in psychiatry reflects the tendency to apply disease labels to a wider range of social behaviour.

Even when they are not, like ME, mystifying, the new diagnostic labels are descriptive rather than explanatory. Far from opening up the prospect of treatment, they merely confirm the hopelessness of the sufferer. The labels validate and legitimise the expression of incapacity in medical terms. Whereas diagnoses in the past suggested the limited character of the condition, the new labels imply disorders that are unrestricted in the scope of the symptoms to which they give rise and in the duration of their effects. Post-traumatic stress disorder or recovered memory syndrome, for example, can be expressed in the widest variety of symptoms, which may arise long after the traumatic events believed to have triggered them.

The depersonalised character of traditional diagnoses allowed the sufferer to objectify the condition. In contrast, a diagnosis such as CFS/ME is inescapably personal in character. Every sufferer exhibits a different range of symptoms, and there is no way of objectively confirming or monitoring the course of the illness. The net effect of the dramatic expansion of the range of medical diagnosis is that, instead of conferring strength on the patient, it is likely to intensify and prolong incapacity. The proliferation of such diagnoses and their application to increasing numbers of people is not only damaging for these individuals, it is demoralising for society as a whole.

Michael Fitzpatrick

How NOT to be a walking billboard...

Part 1 in an occasional series

In the February 2002 issue of the *BJGP*, doctors were implored to refuse to sell ourselves as walking billboards. (Cooper RJ, Hoffman JR. Selling drugs to doctors - it's marketing, not education. *Br J Gen Pract* 2002; **52**: 168-169). Some practical guidance is required.

This month the **Post-It note**. Cost per 1200 Post-It notes, WH Smith (March), £3.49. At Lanarkshire full-time principal usage rate, 1200 Post-It notes will last for one year. Cost per day, 0.95 pence. Percentage of full time principal's annual income spent on Post It notes = 0.0058%.

Next month replacing a pharmaceutical tuning fork ...

Alec Logan

Doctors on the Edge: GPs, health and learning in the inner city Linden West

Free Association Books, 2001
PB, 240pp, £16.95 (1 85343522 8)

A General Practitioner, his Patients and their Feelings: Exploring the Emotions behind Physical Symptoms Sotiris Zalidis

Free Association Books, 2001
PB, 256pp, £16.95 (1 85343527 9)

Narrative Approaches to Working with Adult Male Survivors of Child Sexual Abuse: the Client's, the Counsellor's and the Researcher's Story Kim Etherington

Jessica Kingsley Publishers, 2001
PB, 336pp, £15.95 (1 85302 818 5)

THE creation of stories about our own and others' lives, such as patients, enables connections between characters, events, time and place. We constantly create and share such stories; our way of making sense, and of making informed actions. The ensuing chapters of the stories. These three books concern how to understand and handle this story-making process reflectively, reflexively, and dynamically. They also offer fascinating windows into others' stories.

Linden West's book is the result of extensive, in-depth, longitudinal collaborative auto-biographical research among 25 inner-city GPs. A compulsive read, it could be seen as dismal: overstressed, overstretched doctors struggling to balance home and work, becoming cynical, or near suicidal. Yet these 25 stories which interlock with the understandings Linden draws from them, as well as background and theoretical information, shows us 25 people struggling with conscience, care, and concern.

But the picture of the tottering health service is far from heartening. These 25 are not dragged down by inner-city crisis, or post-modern chaos, but by lack of person-power and resources, and the pig-headed focus of the NHS on attempting to mould them into neo-scientists, and neo-business-people with no time to listen, make connections, or care. A follow-on to *A Fortunate Man*, and Sinclair's *Making Doctors*, it of course lacks Berger's emerald spectacles. We know Sassal killed himself. The book's cover is funereal.

Sotiris Zalidis' book tells of his research into whole-person or psychosomatic medicine in general practice. This involves an understanding of psychological, biological and sociological systems and their interaction and integration in each patient. It seeks emotional as well as physical links with health. But of course such medical understanding is deeply complex: it does not come up with magic answers. And it

requires the doctor to make an effort to understand their own emotions if they are not to be mere mechanics of the flesh, as one patient put it.

Zalidis gives well-expressed graphic examples from his practitioner research to illustrate how many disorders, such as shingles, are clearly related to emotional upheavals in patients' lives. He also describes how he enables patients to communicate. One is to ask: what are you afraid of?

My only quibble with this book is the dull blue and grey of the delightful cover bird with the oddly deformed wings. I'd have this soul-bird bright yellow.

Kim Etherington's book tells the story of brothers (GP and nurse) sexually abused as lads, and their counselling with her. This account clearly demonstrates the power of narrative, writing, and the value of paying attention to emotions and feelings. The book's subplot tells the story, lightly sketched, of how the author's own childhood abuse led her to this work. The third theme concerns her methodology.

This text offers insight into how being listened to, respected, responded to, and encouraged appropriately can enable even the most grotesque stories to take shape, be pulled apart and re-created into more healing ones. An engaging read, it's slightly too long and chatty, making it a heavy tome reinforced by an unpoetically clumsy title and formidably dull cover.

These books demonstrate the deep value of reflexivity and reflection upon one's own practice and its relationship to personal life, the role of story and narrative both in understanding ourselves and our patients, and the effectiveness of paying attention to the full range of our own and our patients' being: physical, social, spiritual, and emotional. This is a complex business and must be accepted as such.

Gillie Bolton

Richard III

The Crucible Theatre, Sheffield
Directed by Michael Grandage

KENNETH Branagh returns to the stage after ten years. His Richard III is a charismatic rogue, a flawed anti-hero with a quick wit and sideline in cutting humour (a Hollywood reference: think Bruce Willis in *Die Hard*). This Richard sets out to charm us, firstly by revealing his soft side, a physical deformity that barely impedes his drive and ambition, and secondly by his anarchic mockery of the titled gents around him. This is a Richard who has us believe that his cruelty and murderous ways are merely symptoms of the time and a necessary evil to help make England united after her civil war.

We first see the Duke asleep stretched on a rack-cum-climbing frame-like device, callipers to the head, clad only in a pair of white (anachronistic) underpants. Once released from the clamp, Branagh twists his body into a natural hump, hunched over and crippled, barely able to crawl until he clothes himself in a corset which pulls his body upright.

This machinery is one of the few stage props in the play. The spectacle relies almost solely on the words and clever interplay of characters in mainly sombre coloured costumes. The audience look down upon the actors in the intimate setting of the Crucible, but it is only Richard who addresses us directly as co-conspirators. We laugh with him.

His route to the top is slow but sure in the first half, his descent rapid in the second. As his downfall proceeds the humour is lost, and without this we can only despise him and his evil mind. The night before Bosworth, back on his rack, he is visited by the ghosts of his victims who perch upon the frame and haunt his dreams. The young murdered princes play upon this climbing frame, now he is totally at their mercy. He rises a broken figure both mentally and physically, smaller in stature, prey to his doubts.

Richard's final costume is a curious jacket of muscles and bone, an anatomist's dissection, with vertebrae on show along the back (another film reference: Richard as Predator?). Richmond is a mere boy compared with his rival, god-fearing and dull. But he wins the strangely stirring battle, well staged even with so few protagonists.

Branagh as Richard was superb, the rest of the cast excellent, especially Phyllis Logan as Queen Elizabeth, Danny Webb as Buckingham and Avril Elgar as the Duchess of York. The leading man dominates the stage, but does not unbalance the performances and the actor does not swamp the character.

Jill Thistlethwaite

blair smith

The Philosopher of the Ring: Book 1: The Tiredness of the Ring

OUTSIDE the building, darkness descended and swirling mist rose in spirals to meet the eerie lamplight. Above, the clouds parted briefly to reveal a sliver of moon, before closing over again in a final ghastly portent. A chilling wind seemed to emanate directly from the growing night, and enter the surgery through unseen gaps in the wall. Dr J K K Rowlkein's heart sank as he listened to his patient's continuing account of treatment failure.

and I didn't even know I had an illness at all, until the Department of Health's report created chronic fatigue syndrome.¹ Even so, doctor, you should give treatment that actually works. I mean something has to be done, droned the man, limply exhaling blue smoke from a suspiciously hand-rolled cigarette. As director of the Primary Care Trust, I am deducting 50 points from Rivendell Medical Practice.

I can't understand why the herbal remedy didn't work, Professor Mucus, gasped Dr Rowlkein. I read a recent randomised controlled trial that confirmed its efficacy in cases just like yours. Let me get the paper from the practice library, it's just in the next tower. I'll be back in a twinkling, his voice faded as he descended the great staircase.

Faced with a wall of journals, it took some time to locate the correct volume. He was surprised to note a strangely familiar shadowy figure leaving the library, having just replaced the precise journal he sought. However, his literature search was in vain, and he returned to his surgery empty-handed.

Well, really, doctor, continued Mucus. You need to be more up to date than that. I will give your continued accreditation serious thought. Good to day to you. And the Trust director left the room. With a sigh, Dr Rowlkein pressed the buzzer. He raised an eyebrow when his next patient turned out to be a goblin.

"Ssssss. Hello, doctor", hissed the creature slimly. I am Bolus, the Keeper of the Ring. I'm also a philossopher (to make the story tie up with the title). If you twissst this ring on your finger three times, you will go back in time to whenever you wish.

Rowlkein digested this. But, that's impossible. Wait a minute, though. If it were true, I could go back three years, conduct a randomised controlled trial (RCT) of magical intervention in chronic fatigue, and publish the results before Mucus comes for his appointment! Then we'd get our 50 points back.

Yesss, dripped Stridor. Try it. So Rowlkein did, and found himself spiralling through the calendar, watching deadlines passing in reverse, and landed in his own office three years ago. The next part of the story is a long and adventurous tale, of magicians and scientists, wizards and gatekeepers, courage, determination, stamina, and elves. I suppose an unfeasibly large trilogy could be devoted to its re-telling, amid wood fires and smoke rings. For now, though, be satisfied with the primary outcome measure, which was an RCT of mandrake root in chronic fatigue, funded by the Hagrid Memorial Trust, producing a clinically and statistically significant treatment effect. At times, Rowlkein was disheartened, and close to giving up, but he was driven by his memory of the trial he had previously read, which showed him that the methodology was feasible. Rowlkein's eventual publication in the Black Magical Journal (*BMJ*) achieved less acclaim than it deserved, but it did allow him to obtain a leather-bound volume with his results, for placement in the Rivendell Practice library. This he completed just in time, placing the book on the shelf and effecting a hasty exit from the library, as his own recognisable footsteps entered through the other great door.

Neatly back in his own time, he anticipated Professor Mucus's review appointment, this time, of course, producing his own paper on chronic fatigue treatment.

Why, said Mucus contritely, you're right, the treatment does work, I can see that. In that case, I must be cured. Thank you, Dr Rowlkein, and may I add my congratulations on an elegant study. Fifty points to Rivendell!

Reflecting later in his dormitory, Rowlkein asked himself where he had discovered the inspiration for his research, and, realised it was the enigmatic recollection of his previous reading in the field. But, he thought, I never found that other paper. Could it be that I was both remembering and inspiring my own work? It must be true! But how on earth will I stretch that to three volumes?

Muggles can find the answer to that question just in time for the next school holidays.

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Körperwelten (Bodyworlds)

Atlantis Gallery, Brick Lane, London E1

23 March – 29 September, 2002. www.bodyworlds.com

I still haven't made up my mind about this exhibition. My first reaction – revulsion. (So, too, I presume, was that of the person I overheard retching in the gallery toilets).

Professor Gunther van Hagens' collection of dissected human cadavers is now on display at the Atlantis Gallery. However, these are not the flabby grey, formaldehyde-stinking corpses of a medical school dissecting room. These are plastinated, their body fluids replaced by synthetic material, and their colours are similar to those of plastic anatomical models.

Having got through the gallery doors, I softened a little. Something to do, I think, with the fascinating walk down Brick Lane to get there, and my discovery that Channel 4 was featuring the exhibition on one of its documentaries, an endorsement which gave it a bit of credibility in my eyes.

The most interesting exhibits were not the whole dissected bodies, but the diseased organs: the black, tar-stained lungs, the carcinomas, the hugely hypertrophied heart. I'm not a doctor, though, and I'd be surprised if any GPs would find very much to interest them here. For the public, it is a different matter. Where else would they get to see such things?

One thing that bothered me was that this exhibition seemed to fall between two camps. Surely this can't be art: where would be the ethics in that? But if this is not art, why the need to show a body sitting at a chess game? And what about the body displayed on a rearing (also dissected) horse? I'm not convinced, either, that claims that this exhibition will make people go away and think more carefully about their health are all that valid. Unfortunately, I don't know what will prevent schoolchildren from taking up smoking, but I'd be very surprised if the sight of a pair of black, plastinated lungs in a display cabinet would do it.

The more I saw of this exhibition, the more unanswered questions I had. What, for instance, had the people who had lived in these bodies actually died from? I would really have liked to know. In particular, what was the story behind the pregnant woman who was displayed with her unborn child? (In actual fact, I looked around twice and couldn't find her in the exhibition). She must have given her consent to plastination. In this day and age, why couldn't they have been saved?

At the end of the day, though, the big question must be: is this or is this not a freak show?

Sue Molony

BRICK Lane in East London is an unlikely place to see one of the most remarkable exhibitions I have seen in the last few years.

Bodyworlds – Gunther von Hagens' anatomical bodyfest – is a must.

Professor von Hagen is director of the Plastination Centre at the State Medical Academy in Bishkek/Kirgizstan where he has developed a technique for preserving body organs, shapes and feel. This technique of plastination makes it possible to lend rigidity to soft body parts, such as individual muscles, the lungs or a single nerve. The exhibition is designed to inform visitors and afford the opportunity to better understand the body and its functions and shows what is fascination beneath the surface. It is in the UK for the first time, having had over eight million visitors in Germany since 1997. So what is on offer?

Various exhibits have outstanding artistic value: The Runner with muscles flayed, here the anatomy is beautiful and pretty in an organic way, which is what it is. There's also The Swimmer, also with muscles pulled back, revealing viscera, spinal column, and feet. Other examples are of body organs – the inevitable smoker's lung, diseased hearts and vessels and, most fascinating, multiple joints, some with prosthesis *in situ*. Downstairs the now famous reclining pregnant woman with nearly fully-developed baby visible is positioned in an annex. Next to this are multiple fetuses through various stages of development, from four weeks through to over 30 weeks. There is also the extraordinary latticework of effervescent red blood vessels in various limbs, some in children, that are testament to the plastination process and show a compelling eye for detail.

I thought the whole exhibition was both thoughtful and thought provoking, uncomfortable in places but overall absolutely riveting. It does seem strange that the subject of anatomy, which caused me so much heartache over 20 years ago, is now the talk of the town.

If I had one suggestion it would be to have an idea of who these people were who donated their bodies to von Hagen, and perhaps why. In these days post-Alder Hey and Bristol, a need to have a feeling for the donors seems an almost necessary part of the process whereby the living can view the dead, knowing that the donors had given consent. I sincerely hope the latter is true although I understand this continues to be a controversial aspect of von Hagens' work.

This is an astonishing exhibition, as you will likely to see this year – don't miss it.

Surinder Singh

Thoughts from a retiring Convenor

Gpnotebook

<http://www.gpnotebook.co.uk/>

HAVE a look at this, said the deputy editor so have a look at it I did. This was the GPnotebook database, a web-based medical reference tool. It is said to have 27 752 pages with over 65 000 cross references.

Although I wasn't able to access the site from home I had no difficulty using the NHS net connection and I have to say that I am highly impressed. It is organised into subject headings (cardiology, obstetrics, paediatrics, EBM, etc) and each section has a list of subheadings which you can either browse or search (as indeed you can the whole site). The search engine is quick and easy to use, and I found most things within 15 to 30 seconds. Each article is a succinct summary of information about the topic, backed up by references.

So far as I can tell the entries are accurate and, although not hugely detailed, tell you what you want to know in enough detail to make a decision. For example, I was faced by the problem of a pregnant woman exposed to chickenpox, who did not know whether she had had chickenpox as a child. I searched on chicken pox in the obstetrics section and within a minute or two was able to advise that we could wait over the weekend for the result of serology before deciding whether or not she would need further treatment.

I regularly used other on-line sources of information during consultations (mostly through the National Electronic Library for Health), such as the Cochrane Library, Clinical Evidence and the NICE website, and sometimes Medline and Google. While these are all useful, they often take some time to use and may (in the case of the Cochrane Library, for example) give very large amounts of text to wade through. GPnotebook is quicker and is now my first choice for background knowledge. I wholeheartedly recommend my colleagues to add this to their list of favourites and use it as their first stop for information. Even if they are wary of more complicated sites, comparatively inexperienced net users will find it straightforward to use. It would be an excellent choice as the first regular in-consultation on-line information source.

The URL is: <http://www.gpnotebook.co.uk/>

Enjoy!

Toby Lipman

FIVE years ago I succeeded Lesley Southgate (as she then merely was) as Convenor^a of the Panel of MRCGP Examiners. We marked the transition with an exchange of gifts. Professor Dame Lesley PRCGP, (as she now illustriously is), gave me an intriguing trinket. It was spherical, about an inch and a half across, metallic, Chinese, lacquered, black, patterned with dreamy grey clouds and a cross-looking red dragon.

The symbolism wasn't lost on me. Like the MRCGP exam, the bauble, though exquisite in design and beautifully crafted, is more an ornament than one of life's essentials. Like the Panel, it's weightier than you might think from the size of it. And it shouldn't have surprised me - its polished exterior betrays nothing of the intricacies concealed within. For when you lovingly caress my Chinese ball it emits musical sounds; a touch twangy and occasionally inharmonious, but music nevertheless.

One of my first acts as Convenor was to have my name badge re-made. If you visit Princes Gate only occasionally, they issue you with a cheap plastic thing containing your name on a card and mounted on a brutal safety pin. But if you look like you'll be there quite often they supply a more clothing-friendly item, worn round the neck on a rope of silvery beads.

I got one of these. But I've always been a rebel, and I didn't like the way my name was starkly typed in a bland 'who cares?' sort of font. So I changed it. I printed out Roger Neighbour, Convenor, Panel of Examiners - not in conventional pinstripe-and-briefcase Times Roman, nor even in the suave elegance of Arial. For my badge of identity I selected the quirky Comic Sans, 20-point, bold. I don't suppose anybody else cared, or even noticed. But to me it betokened a touch of subversion, a subliminal proclamation that I was *among* you but not of you.

But (*Question*) why should the academic lead of one of the College's flagship institutions feel a need to resort to such a gesture? (a) Because he's a rebel; (b) because the exam is a touch anarchic; (c) because there's something in the College air that can make even its most loyal activists resort to childish games.

Answer: all of the above. But (c) comes closest.

It's often said that the exam is the jewel in the College's crown. Certainly it has earned the respect of the national and global community of assessment experts for its unsurpassed indices of reliability, its quality control procedures, and the commitment of its examiners. The MRCGP exam has been admired and studied, even copied, by other Royal Colleges. Candidates by and large feel fairly treated, even (with a few vociferous exceptions) those who fail.

Unfortunately, the exam operates in a murky political context where academic probity is no reliable armour. It finds itself too often at the mercy of devious manoeuvrings by professional rivals and the hidden agendas of vested interest groups. Granted, the exam must take its policy steer from the College. But if that steer is actually someone playing games about summative assessment, or a tactic to impress the Government, or a slap on the wrist to stop the examiners getting uppity, or a Faculty with an axe to grind flexing its muscles, there is a danger of real harm being done to the delicate machinery that keeps the exam doing what it's designed for - assessing the competence of aspiring members of the College. As a battery of tests the exam is first class. As a shuttlecock it's lousy; hit it too hard or too inexpertly and the feathers start to come off.

Peter Tate, my successor, has a fine track record in the teaching and assessment of consulting skills. He is a resilient man with a lovely chuckle. At the recent ceremony marking the transfer of Convenorship my present to him was a chalice. We joyfully drank champagne from it, and joked about whether it was poisoned. For I have two wishes for Pete. First, that he enjoys the job of championing the exam's academic standards as much as I have. Secondly, that people will let him.

So hang on to your chuckle, Pete - you'll probably need it.

^a You may wonder why the examiners' elected leader is called a convenor, someone who calls people together for meetings. If anything, the role requires skill in the herding of cats, eyes in the back of one's head, and a grasp of weasel. The post used to be termed Chief Examiner but, following a spot of bother in the 1980s when one of my predecessors got into trouble with Council for lamenting correctly but too publicly that Trainees didn't seem to go in much for reading, the present anodyne title was imposed.

uk council, march 2002

Appraisal

Council discussed appraisal, with the major focus this time being appraisal in England. Most GPs in England will probably be aware that the Chief Medical Officer for England announced that annual appraisal for GPs is to be introduced in April 2002. So far, the scheme only applies to GP principals and their Personal Medical Services equivalents. Although the NHS Chief Executive in England has written to PCTs emphasising the importance of making appropriate financial provision in support of the implementation of appraisal, there appears to be no guarantee that PCTs will make resources available for adequate protected time for appraisals. The paperwork also looks rather daunting. We shall be supporting GPC to resolve these issues in their further negotiations.

It is good to see that the documentation issued refers to a strong recommendation to use both the GMC's *Good Medical Practice* and the College's *Good Medical Practice for GPs*. The latter document is now on our website and will be circulated in hard copy form to all GPs soon.

Progress on appraisal in other parts of the United Kingdom was also reported on.

GPs with a special interest: RCGP support

I brought to Council a paper I had prepared with Dr Claire Gerada, which considered the proposed role of the College in co-ordinating the work of establishing the context of GPs with a special interest in a variety of clinical areas. The paper was prepared in an English context but consideration will need to be given to the implication for Wales, Scotland, and Northern Ireland. You may be aware that we have already published two papers on GPs with a special interest – the first in March 2001 on the concept and the second in September 2001 on the process for establishing GPs with special interests. Those papers looked at all types of special interests, both clinical and non-clinical (these are on our website). The current paper concentrates on clinical interests.

The paper concluded that work relating to GPs with a special interests needs to involve bodies, such as the Department of Health, other Royal Colleges, and specialist associations and primary care clinical societies, all of whom are looking to this College to co-ordinate and develop the work. By agreeing to take on this work, the College will be able to support GPs who would like to take on a special interest and patients will benefit from enhanced service provision. We shall need to ensure that this work is adequately resourced and as we have said all along this new development must not undermine or compromise generalism.

Council was supportive of the approach proposed and recognised the opportunities which it presents for the College.

Future of general practice

Our Chairman, David Haslam, has been considering for some months the need to have a debate on the future of general practice, building on the foundations of our previous work and papers. Council had an initial discussion of the issues, such as workforce, skill mix, access, and continuity of care. This was against the background of discussion documents, such as the Wanless report and the recently issued BMA paper *The Future Healthcare Workforce*. CEC will be taking these issues away for a longer discussion at its workshop next month with the aim of bringing back a paper to a future Council meeting.

Council recognised that simply keeping with existing models is not a reality but, at the same time, any framework which forces patients to accept only one model of primary care is inappropriate. Council's preliminary view was therefore that patients should have choice. This means that they should continue to have direct access to the primary healthcare professional who is most appropriately skilled to carry out their diagnosis physically, psychologically, and sociologically and to negotiate a management plan for them. This is an area where there are bound to be wide-ranging views and you are very welcome to add your voice to the debate as it goes forward.

Quality indicators

I brought to Council a paper I had prepared jointly with Professor Martin Marshall of Manchester and Dr Tim Wilson of the College's Quality Unit. I had revised the paper since the first discussion by Council in January. The paper concludes that the College should support the use of Quality Indicators within certain parameters relating largely to context and professional relevance, and aimed at improving the quality of service or of clinical care received by patients.

Council was supportive of the paper and it will be published as a position statement in due course.

Organ donation

Council was pleased to support a revised version of guidance for GPs in dealing with issues raised by patients and their relatives about organ donation. It originated with our Medical Ethics Committee, which receives regular reports on the work of the BMA-led Organ Transplantation Group. It is an attempt to explore the ethical issues arising from organ donation and seeks to better inform doctors when responding to questions raised by patients and their families. Council was supportive of the

Updating the College

constitution: consultation process
All members of the College should have received with the March issue, of the *BJGP* a consultation paper about our constitution. This included a response form asking for views on a number of questions. We have already had back an encouraging number of responses – the closing date for comments is 26 April 2002 and you can feedback your comments by post, by fax, by email or by using the electronic version of the response form on the College's Website at www.rcgp.org.uk/rcgp/corporate/consultation/constitution/constitution_menu.asp

If you did not receive a copy of the form with your copy of the *BJGP*, please contact Andrew Hall at the College at andrewh@rcgp.org.uk

If you would like any further information about any of the issues in this letter or about any other matters discussed at March Council, please get in touch using honsec@rcgp.org.uk

MESB

JIM Cox's excellent editorial (*BJGP* March 2002) excluded, the medical profession awoke rather late to the government's latest plans for postgraduate medical education. In case you missed the details, all curricula, syllabuses and approval for training placements will be overseen by the proposed Medical Education Standards Board. Its composition will be 25, including the medical profession, patients, the public, and the NHS. Its chair may be a lay person. It will be answerable to the Secretary of State.

A document was published in November 2001, and the consultation period ended on March 4th. If consultation means what it has meant in recent times, the outcome may be focus groups requesting the replacement of the medical profession by crystal therapists and craniosacral osteopaths.

As with all things political, the rhetoric starts early, in Mr Milburn's introductory letter (Dear Colleague). The UK's doctors do a brilliant job for patients, writes cuddly Alan. Remember that this is a document which even before the reader has looked further is clearly going to suggest big changes to medical education. Which explains the flattery.

Milburn continues, Our country has some of the best doctors in the world. Our system of medical education is rightly admired throughout the world. This reader's immediate response is to ask why, therefore, it needs seismic change. We are not given a clear reason, only, But change is needed, because health care is changing.

There is nothing in Milburn's foreword or anywhere else that really explains what this means. Health care has always changed. What is so special about the changes now? Repeated at intervals in the document are three things—the need for quality in healthcare, with its implication that this was something doctors did not think about in the past; the need for healthcare to be patient-centred, though there is no explanation of how this gives patients the ability to decide what should be in the curricula for vascular surgeons or forensic pathologists; and finally the curious idea that the NHS has no say in how doctors are trained. But what is the NHS?

The true motive is revealed by the example of an A&E department closing because of withdrawn training recognition: how can the government supply enough doctors if them pesky Colleges insist on standards?

Perhaps someone could also explain how patients differ from the public; and could point out to the DoH that some doctors if the training is such that he [sic] has reached the standard are women.

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paper and subject to some final changes, we hope to publish this in due course.

European Union Title III/Title IV

Our Education Network has been developing views about the College's position on Title III/Title IV. The EU has developed a number of titles under which professionals are trained, Title III relating to the training of medical specialists and Title IV to general practitioners or family practitioners. All UK GPs are currently trained under Title IV. Training under Title IV is more prescriptive than under Title III. However, some EU countries are already refusing to allow doctors qualified under Title IV to work within their social security systems, thus driving a move to training under Title III. This is currently in breach of EU directives and might be subject to formal proceedings.

The Education Network feels that, on balance, a move to Title III is the best way forward for UK GPs. This will depend on a number of factors including the introduction of the general practitioner register and the advent of the proposed Medical Education Standards Board. Council agreed that when the general practitioner register is introduced, the debate on the case for moving GP training in the UK under Title III should continue.

Quality Network

It is our practice in Council to receive a detailed report on activities from one of the College's Networks or Committees on each occasion and this time it was the turn of our Quality Network. The Network is concentrating on bringing together the College's Quality Awards into a more coherent set of awards and aligning procedures and practices wherever possible.

The Network has also been considering how best to respond to the motion from the North East London Faculty brought forward at the November 2001 Council Meeting concerning the use of *simulated surgery* as an alternative to the video for the consulting skills component of the College Examination. The Quality Network and the Examination Board intend to carry out a wider review of the content of the examination and assessment structure and would prefer the issue of candidate choice in the consulting skills component not to be considered in isolation. A small subgroup of the Network has been set up, including representatives from the Education Network, a registrar representative, a patient representative, and others as well as members of the Quality Network. There will be an interim report to Council in June and a fuller report in September.

Maureen Baker
Honorary Secretary

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Caught on the horns of a dilemma

As I have already confessed, we only have sheep at all because we had a spare patch of land and they were otherwise destined to become dog food. At the time, it seemed like we were liberating them, freeing them from the very mouth of hell. Not that we ever really reflected on this at the time, but somehow we felt that being turned into dog food represented an altogether inferior form of death; our visions were of a grotty, rubbish-strewn abattoir with new ovine arrivals, awaiting their own turn, being forced to watch their kinsfolk rudely cut up and forced into tins.

So by comparison with the fate we imagined ourselves to have rescued them from, our two sheep suddenly found themselves in paradise. Albeit a ragwort, nettle and thistle-strewn version of paradise (but then all things are relative, remember). Besides, they actually showed some goat-like traits and started eating some of those undesirable elements of their new home's vegetation, along with some of the desirable elements like wildflowers and trees. Gradually they began to help return what had started out looking like waste land to an appearance closer to the small meadow we aspired to.

And then, in the first spring they were in our care, they produced a lamb, a little fluffy black lamb. Right from the start it proved to be decidedly hard to catch, always seeming to produce one last spring to escape our rugby tackle approach. Our ideas soon evolved however, becoming perhaps marginally more sophisticated than simply trying to run the little blighter to ground, and we eventually caught it. Thereupon it proved to be a he and he had undescended testes. We were forced to let him go and try again on another day.

In the end we must have caught him three or four times before the time we did and his testes were there. Then, with a second-hand 1950s farming textbook at hand and a borrowed, rather finely engineered device called a Burdizzo, we castrated him. It made us wince but we did it bravely. As for him, he had rather less spring for a while after.

And it is from that point onwards that our master plan has unravelled. That it has done so as gradually as the enlargement of his scrotum is no great consolation because we have spent a long time in utter denial. Now, however, he is as big as his father and his horns have curled back on themselves in such a way as to show he is no eunuch: denial is impossible.

In the autumn he sparred with his father over who should get to have his way with mother. His father won, we are sure, but his father is getting on a bit, gets corns in the winter and certainly can't stay in charge forever. Worse still, there is a younger sister now and mother is expecting another lamb this spring. The family unit is growing and incest is soon going to be an issue.

Foot and mouth disease means that giving away a ram is not at all easy now. Added to that, he turns out to be an unregistered example of his rare breed. And then of course, there is the possibility we gave him a vasectomy when we tried to castrate him. Even eating him ourselves is a problem because he is too old and too male to make for tasty meat (not that we could really do this, we tell ourselves).

So the only option left is dog food. And a goodbye to any remaining illusion that being a GP makes me a master of all trades.

In the *Back Pages*, June...

Frank Gehry

... interviewed
