The Back Pages

viewpoint

The new contract — worth voting for?

Any Viewpoint written for this issue, with a contract ballot result expected within days, is necessarily speculative and this edition of the *BJGP* could be the last published in the general practice world as we know it. Most members of the BMA s General Practitioners Committee (GPC) hope that the result is positive, allowing further negotiation and progression to pricing. Some sceptical doctors, however, have campaigned vigorously for a negative vote, possibly leading to resignation . At present it is unclear whether that would be of family doctors from the NHS, or of their negotiators at the GPC! Positive or negative, the pent-up frustration of general practitioners (GPs) and the expectation of an improvement in working conditions and rewards mean that the genie of change will not be returned to its bottle. Ironically, whether or not they are supporters of the new framework, the vast majority of UK family doctors have the same aims.

Most doctors believe in quality . The dispute comes when one tries to define quality, or adequately to measure it. Most doctors believe in skill mix and demand management, but a one size fits all approach to the social, geographic, and demographic diversity of UK general practice fits uneasily into what they perceive as their uniquely disadvantaged practice circumstances. Most doctors believe that the current system of organising general practice is unsustainable in the face of a crisis in recruitment and retention in the foreseeable future. They deeply distrust local, regional, and national NHS structures, not to mention their cynicism over the pervading influence of the Treasury over Government policy.

As with all institutions, general practice has to change to survive. While a retreat to pre-1948 independent practice is possible, any professional fees would rightly be accompanied by heightened demands for quality and accountability whether those fees were paid by individuals, or by the Government through social insurance.

We face two possible scenarios. The first, and more desirable, is that GPs have voted in favour of more detailed negotiation and for pricing of the contract, but from a sound base of existing arrangements. This would maintain an increasingly precious independent contractual status, a secure, if hardly generous pension, and continuity for our incomes, for our staff s employment and for patient care. Improvements would not be instant or dramatic, but there would be an agreed timetable for their introduction.

The second scenario is one that denies the GPC negotiators the opportunity to put flesh on the bones of what they have so far presented. This would be manna from heaven to the It ain t fixed let s break it lobby leading to either a mass exodus to a Personal Medical Services (PMS) contract, or threatened resignation from the NHS.

PMS has its supporters, but its rewards are based upon historical income, contracts are negotiated annually with local health authorities that are constantly destabilised by structural change, and family doctors are denied the protection of national representation. Micro-managers within the service must already be licking their lips in anticipation! Resignation also has its supporters, and indeed it may well be our negotiators weapon of last resort, but a GPC cynic s famous remark comes to mind, The troops are anxious for the generals to go over the top! Independent practice seems to recruit the majority of its supporters from the leafy suburbs but cuts less ice with those struggling to deliver an equitable service in less advantaged areas, whether urban or rural.

We may, however, end up with the worst of all worlds, an equivocal vote that satisfies neither camp, one that enables our political paymasters to impose the future on a divided and demoralised profession. In the middle of all this there is the single most important element of all, our patients. At the moment they are amazingly tolerant of practice difficulties that sometimes compromise quality. They understand that longer consultation times reduce appointment slots and hence access, they realise that we struggle with inadequate nursing and administrative support and they know that the golf course is no longer the preserve of doctors on Thursday afternoons.

There are two fundamental truths to come out of what faces us all during the summer of 2002. First, a seminal issue: it is our patients who will decide what we are worth to Society, whatever the details of a future contract. Second, the contract we end up with must be predicated on the needs and aspirations of family doctors that are just starting in their career and of those who will come after. We must not lose our corporate, professional memory but retrospection to 1990, 1966, or 1948 is far less likely to bring improvement than our embracing new horizons.

Brian Keighley

"I've always had GP stamped on my bum … I'm independent minded and bloody-minded and I hate being told what to do. I got the impression that in general practice you could really rule your own life."

Christopher J, *in an Oral History of General Practice, 'Paisley Docs', Part 2*, page 604, and online at **http://www.shef.ac.uk/~scharr/hpm/GS/**

"General practice is exhausting, frustrating, and sometimes terrifying. Yet it remains deeply rewarding ... What we need is more time and support — not a different job."

Iona Heath, on our New Contract, page 602.

contents

Dr Keighley's Viewpoint is a personal contribution. While he is a member of the GPC, SGPC and BMA Council, he saw the Contract document for the first time on 18 April 2002, and has had no part in its formulation which has been the sole preserve of the GPC Negotiating Team.

THE contract currently on offer to general practitioners in the UK is a patchy document. Two aspects stand out.

Limiting the core task to the care of those acutely ill and expected to get better, and the terminally ill, is simply astonishing. Excluding the numerous patients with chronic conditions whom we try to help live long and fulfilling lives is only part of the surprise. The other is to ignore the larger number where we struggle to disentangle the emotional and physical elements.

Secondly, there is opting out of a wide range of services. As an answer to the difficulty of continuing to provide core services when there is such a desperate shortage of doctors and nurses, it s superficially attractive, assuming of course that PCOs succeed in conjuring up alternative suppliers. But what are the patients supposed to make of this? How, as a patient, will you handle your local practice abruptly deciding to stop offering contraception or immunisation services? This vision abandons any notion of comprehensive and continuing care, again re-emphasised in last month s *BJGP*. But in the longer term, the gloomiest view is that patients, obliged to keep checking precisely what their local practice is and is not providing today, will be unable to reconcile their image of what primary care should be with the one that the NHS offers.

Faced with the difficulty of balancing the needs of patients with the current crisis in recruitment and retention, the negotiators have come up with an interesting solution. They presumably think that the short-term gain is to make general practice once again an attractive career option. The long-term risk is that we shall collectively provide less and less of what our patients need, and be increasingly marginalised within the NHS.

David Jewell

Whither continuity of care?

FOR more than 50 years, UK general practice has offered both universal access and a contractual link between an individual doctor and an individual patient. In many other countries, such an arrangement has been available only within the private sector. The registered list system has actively fostered continuity of care and has enabled the UK health care system to punch well above its weight on the world stage. Historically, UK healthcare statistics have been far better than would be anticipated by the comparatively low levels of funding and the relatively inadequate provision of social support. As De Maeseneer, Hjortdahl, and Starfield predicted two years ago, the new GP contract seems set to destroy the link between named patient and named doctor, and thereby to fix what s right and not what s wrong.

In future, all contracts will be with practices and not with individual professionals. GPs will lose completely their responsibility for out-of-hours care. Of course, doctors should have the right to work within their capacity, but a new contract for UK general practice should build on the strengths of the past and offer powerful financial incentives to support and promote continuity of care.

Whose quality?

The vast bulk of the quality marker payments appear rooted in the requirements of public health rather than general practice. Notionally in the cause of equity, the utilitarian public health agenda is being actively imposed on the fragile good of the clinical encounter. There is a fundamental conflict between population-based public health objectives, with centralised control and a strong emphasis on cost-effectiveness and equity (where both doctors and patients become replaceable parts in a larger system), and the individual focus of patient-centred care. Patient needs extend far beyond the biomedical and are easily marginalised if the agenda of the consultation is dictated by forces outside it. If the patients feel that their concerns are unheard and their predicament not understood, concordance with treatment plans is proportionately less likely. Much of the political history of the last century demonstrates how easily utilitarianism at a policy level can degenerate into the coercion of individuals. Toop and Richards drew attention to the huge potential opportunity costs of implementing just the cardiovascular National Service Framework (NSF) within general practice[1] but, apparently, no-one was listening.

My unease goes further and, with my usual instinctive paranoia, I wonder about the hidden influence of the World Trade Organisation. A fragmented system of primary care invites cherry-picking of parts of what should be a co-ordinated and cohesive service by a variety of for-profit providers. And what possible justification is there for the inclusion of the menopause in the list of conditions proposed for tiered clinical quality markers? Since when has the menopause assumed disease status? Who stands to gain most from such a precipitate reclassification women or the pharmaceutical industry?

The end of UK general practice?

The profession which emerges from these contract negotiations seems unlikely to fulfil the new definition of general practice to which the UK has made a huge contribution and which, ironically, was launched in London at the WONCA Europe Conference within days of the first ballot on the new contract proposals.

General practice is exhausting, frustrating, and sometimes terrifying. Yet it remains deeply rewarding. Fostering and witnessing the astonishing capacity of ordinary people to recover from, cope with, and endure all that illness and disease inflicts, remains an extraordinary privilege. What we need is more time and more support not a different job.

Iona Heath

Reference

1. Toop L, Richards D. Preventing cardiovascular disease in primary care. *BMJ* 2001: **323:** 246-247.

IN general *Your Contract, Your Future* is a disappointing document. It mentions a dire recruitment and retention crisis in general practice, but does not present a new vision of general practice to which energetic young doctors are likely to be either attracted or committed. There is also an unfortunate tone of retreat from clinical responsibility and the authors are unwise to make repeated references to GPs desire to reduce (manage) their workload. The survey of GPs that generated these data was written in a way which invited negative responses about workload and, given the difficulties that many GPs currently experience, it is hardly surprising that a substantial number of us said that we wanted to do less clinical work.

Unfortunately, beyond that, the nature of workload has not been considered. The idea that patients are either acutely ill and get better, or are chronically ill and die a not too unkind paraphrase of what this document says is only part of the story; we are more likely to be ground down by patients non-clinical, insoluble, psychosocial, and personal problems than by patients with colds or coronaries. Similarly, though the evidence base guiding the quality frameworks may be sound, the evidence base for suggesting that workload concerns dominate everyone s thinking about the future of general practice is less sound. It would have been helpful to look in more detail at what workload actually consists of and then think of ways to help GPs with the really difficult parts of that, rather than imposing extremely complex quality ladders on the strictly clinical topics, which are rather less challenging.

While I like the idea that quality of care should be rewarded, it is notoriously difficult to measure, and I am afraid that this document

still looks like a recipe for box-ticking. This contract will encourage practices to recruit more IT and administrative staff, to generate more data, to earn more money, rather than actually provide better clinical care. The reality is, of course, that we need more doctors.

Meanwhile patient-centredness does not really feature, nor does continuity of care (only mentioned in relation to palliative care). This is a real pity, because deconstructing our general practice system is likely to have dire consequences. New Zealand provides a recent example. This new contract was a real opportunity to look again at the ways in which personal continuity of care can be provided to patients who need it, but there simply isn t enough about that.

And, predictably, there is little here about non-clinical components of general practice. We are still fossilised in Red Book views about the nature of the task of general practice. I would have liked to have seen a much bolder attempt to endorse the mixed portfolio approach to general practice, in which patient care is combined with other non-clinical activities, notably research and teaching. There is, at least, an evidence base for this in London, where we have shown that providing clinical placements linked to sessions in academic departments has a positive effect on recruitment and retention of young GPs in the inner city.

It is difficult to see how some of the out-of-hours recommendations are going to be implemented in areas where it is very difficult to find deputies and locums. Rather than providing a series of opt-out clauses for practices to do less out of hours, it might have been an opportunity to introduce a wedge-shaped out-of-hours commitment, with substantial out-of-hours work in the early years, tapering to a considerably reduced commitment for more senior doctors. This would, at least, ensure that GP co-operatives continue to be staffed largely by the doctors who, working in the locality, provide clinical care during daylight hours.

Our negotiators have, I believe, missed a chance to re-invent general practice as an attractive career with a progressive career structure. Occasionally it is possible to glimpse the notion that there is more to general practice than patient care and to see how other professional activities can be interwoven to create a more satisfying and less stultifying occupation. We are, however, way behind colleagues in other branches of medicine in negotiating a contract in which there is genuine, remunerated protected time for personal development and refreshment, as well as academic activities.

Finally, it would be a disaster if the Government accepted this contract as a proxy for the much more pressing need to increase the number of GPs working in the UK.

Roger Jones

patient participation 4

Self-regulation of doctors: where is the lay involvement?

THE Medical Act of 1858 created the General Medical Council (GMC), defined the new medical profession in terms of the professional skills, standards and training required for doctors and the codes of ethics governing professional practice based on the principle of state-sanctioned self-regulation. Social historians[1] suggest that when a new profession emerges not only have the active members within the profession to be prepared to improve the standards of performance of the profession and raise its status, but also the public have to accept the very considerable powers conceded to professional bodies. Over the past 150 years, the majority of the public did accept the power of the medical profession and accorded them great status and trust.

Nevertheless, there has always been an articulate minority who have questioned the position of doctors. Pat Jalland[2] suggests that, among middle class women between the years 1860 and 1914, negative comments about doctors outweighed positive and the dominant tone was sceptical these women employed the doctors, showed little deferential behaviour, and had no qualms about seeking a second opinion.

Towards the end of the 20th century society has increasingly questioned the principle and practice of medicine. Patient lobby groups, increased availability of medical information to the public, the rise of complementary medicine, the increasing tendency of patients to challenge their doctors or complain about them, have all become more prominent.

Self regulation in any system be it medicine or parliament is built on trust , commented Sir Donald Irvine in 1995,[3] and if a gap grows between those who are regulating themselves and the public they serve, that s when the threat to self regulation occurs. That gap is now publicly acknowledged.[4] While the great majority of individual patients do, and indeed have to continue to trust the doctor looking after them, the public now question not only the competence of the medical profession but also the standards and quality of medical care.

The GMC exists to protect patients by maintaining an effective register of doctors who are fit to practise. According to the GMC[5] the introduction of revalidation should ensure that, in the future, the register reflects more accurately a doctor s fitness to practise. As the public have lost faith in the ability of the profession to self regulate, the process of revalidation must be seen to be more robust and transparent, and based on standards mutually agreed by the profession and the laity.

The standards by which a doctor will be judged in the process of revalidation should be made against predetermined criteria.[6] The standards set out in the GMC s *Good Medical Practice* were prepared for the first time by medical and lay members of the GMC working together. Individual medical Royal Colleges, setting standards for their own speciality, need to ensure that they involve lay people in the process. If lay people are involved as equals in the process of setting the standards on which revalidation is based, then these standards are more likely to reflect the views of the public.

Revalidation will focus on the performance of the individual doctor through yearly appraisal and revalidation every five years. The role of lay people in this part of the process is still not quite clear.[7] Concern is expressed about who the lay people will be, what training they will require and what part they are to play. The role of the lay appraiser will be challenging, possibly intimidating, and will require support and encouragement. We shall need doctors to help us.

It is not known whether involving the laity in the process of the regulation of doctors will ensure that the profession retains the trust and respect of the public. Personally, I think such involvement is essential. I speak as a person and a patient, and I want to be listened to.

Patricia Wilkie

References

1. Kitson Clark G. *The Making of Victorian England*. London: Methuen & Co., 1970.
2. Jalland, P. *Women, Marriage and Politics*. Oxford: Clarendon Press, 1986.
3. Smith R. The future of the GMC: an interview with Donald Irvine, the new President. *BMJ* 1995; **316:** 1086-1087.
4. Salter, B. Change in the governance of medicine. *Policy and Politics* 1999; **27(3):** 143-155.
5. GMC. *Maintaining pace, setting the agend*a. London: General Medical Council, 2002.
6. Southgate L, Pringle M. Revalidation in the UK. *BMJ* 1999; **319:** 1180-1183.
7. Williamson, C. A lay perspective on revalidation and the review of departments of anaesthesia. *Royal College of Anaesthetists Newsletter* March 2000; 31.

An oral history of general practice 2:
Why do GPs become GPs? Family, education and vocation

Transcripts of interviews can be downloaded at the SCHARR website:

http://www.shef.ac.uk/~scharr/hpm/GS/

In my interviews with Paisley s GPs, the doctors (no matter what their age) reported that their parents had influenced their choice of medicine as a career. However, these parental influences were exerted in different ways according to the social class of parents. A separate factor shaping the choice of general practice as a career was the changing conditions in and the subsequent image of general practice at various stages over the past 50 years the attractiveness of general practice has waxed and waned over time.

The family emerges as particularly significant in decisions that lead to the study of medicine.[1] Earlier research suggesting that fathers positively shaped the medical careers of their children[2] was confirmed in our study. Similarly, a large proportion of GPs had fathers in the higher professions , including medicine,[9] science[2] and religion.[2,3]

And it was the authority of these fathers that was recalled as influential in deciding how and where their young would be educated. While some fathers encouraged entry into medical schools, there were others who tried to deter their children, especially daughters, from studying medicine. Such attempts at dissuasion could galvanise rather than diminish ambitions.

For those doctors who originated in families in which parents were employed in lower middle and working class occupations, the role of fathers in career decisions was less pronounced. Among these GPs the importance of teachers and friends at school tended to be stressed. And the role of mothers was more likely to be recalled by interview partners who had been raised in less privileged circumstances.

While the influences surrounding application to medical school have altered little since the Second World War, the motives for entering general practice have changed during the same period. So, when older retired family doctors speak about joining their first practices their narratives are marked by a lack of autonomy. In contrast younger practitioners are more likely to suggest that working in general practice was a positive choice.

The narrated career histories of the younger cohort were less fatalistic than those offered by their predecessors, but there were also subtle differences between the ways different younger GPs talked about their choice of profession. The doctors who qualified in the late 1960s and afterwards would discuss their lack of appropriate attributes and attitudes for careers in hospital medicine. Some believed that they lacked the social capital to participate in a system of patronage. But they also expressed many more criticisms of secondary care than their older colleagues made. Most of the younger GPs concluded that medicine in the community offered a freedom from hospital medicine s hierarchies and regimes. And finally there were those who entered the profession in the 1980s and claimed that this was the only medicine that they had ever wanted to practice. Along with other younger doctors they stressed the promise that general practice seemed to offer.

There were differences across the generations between those who had entered general practice by chance and those who had entered the profession as a matter of choice. That joining the profession is recalled along such distinct lines could be seen as evidence of the outcomes of improving conditions and the subsequent rise in morale that flowed from the Family Doctor Charter and the subsequent contract of 1966.

Change in general practice has also transformed the impact of practice on the family lives of doctors. In earlier times, especially before the 1960s, many GPs had depended on wives to act as receptionists and even as nurses.[4] Practice premises, the introduction of practice receptionists, appointment systems and, more recently, out-of-hours services have meant a separation between home and work. General practice has become an important choice for those wanting a family-friendly option.

In conclusion, the influences leading to entry into medicine changed very little between 1940 and 1990 according to the practitioners who were interviewed. While the mix of entrants remained the same in respect to their social origins, there were changes in the gender composition of entrants. Medicine arranged along authoritarian and hierarchical lines was particularly alien to those who were raised in working and lower middle class households, as well as to female entrants more generally.

There is also evidence of significant changes in the ways the Paisley doctors talk about entry into general practice. A period of low morale in practice, similar to today s crisis, was ended by an improvement in material conditions and future prospects. In the 1970s and 1980s general practice became a positive choice for many, a situation that would improve primary care s ability to play an effective and leading part in the delivery of health services.

Graham Smith

References

1. Twenty-six out of 31 of the interviewed practitioners provided family histories when recalling their reasons for choosing careers in medicine. For further details about the oral history of general practice in Paisley project see the following:

2. Smith G, Nicolson M, Watt GCM. An oral history of everyday general practice: speaking for a change. *Br J Gen Pract* 2002; **52:** 516-517.

3. Bevan M. Family and vocation: career choice and the life histories of general practitioners. In: Bornat J, Perks R, Thompson P, Walmsley J (eds). *Oral history, health and welfare*. London: Routledge, 2000; 21-47.

4. http://www.shef.ac.uk/~scharr/hpm/GS/table3.htm

5. Margaret G was reliant on her mother who would answer the telephone at night (GPP 25).
From An oral history of general practice in Paisley (GPP) interview number 16.

6. GPP 06.
7. GPP 12.
8. GPP 31.
9. GPP 28.
10. GPP 21.
11. GPP 18.
12. GPP 22.
13. GPP 13.
14. GPP 16.
15. GPP 23.
16. GPP 25.
17. GPP 18.
18. GPP 02.
19. GPP 01.
20. GPP 12.
21. GPP 22.

The oral evidence

Choosing medicine

Douglas H: *'All my life I have been led in the direction of medicine. My father would have liked to have been a doctor; he was in the RAMC in the World War I. When I finished school in 1943 I had a notion to join the Indian army. My father told me not to be a fool, I'd be much more use to humanity with a medical degree … As it happened I got my war later anyway ...'*[5]

David R: *'There's always this implicit encouragement of example and it seemed to me that he* [father, a consultant radiologist] *had a fairly comfortable lifestyle. Our family never had to worry about unemployment… that I only realize now is such a huge feature of other people's lives.'*[6]

Eleanor H: *'My mother was definitely subservient. It was his* [father s] *authority that held within the house. He guided me into the scientific school career. I was good at languages at school and he told me that I was to stop French and Latin and do German, 'cause he reckoned that German was the language of science and I still remember that phrase* [laughs]. *…I think he was quite proud that I did medicine.'*[7]

There were some fathers who were against their children entering medicine.

Gerldine H: *'I don't think my dad (who was a GP) was particularly keen for me to do medicine — well he said he wasn't. …I don't think that he was particularly fond of doctors … and I could see his point when I came to university; there were an awful lot of tossers that did medicine. … We were kind of, I'd say, slightly apart from the large majority of the Hutchie* [Hutchesons Grammar School], *Glasgow Academy, Glasgow High or Notre Dame type people. I don't know what school you went to, but I hope I'm not offending you?'*[8]

Fiona T: *'I always wanted to be a doctor from primary school age and that was it. … My dad was a GP. But… I wouldn't say I was particularly encouraged to go into medicine. … My father was very much that I shouldn't do this. Educating women was a waste of time. It was going to cost a fortune and I would get married and throw it all away. I can remember a terrible fight about this. … I held off from having children for a long time … and it came to the stage where my father was getting angry at me for not giving him grandchildren* [laughs]. *And I felt like saying, "Well make your mind up. Do you want me to be a doctor or do you want me to be a wife and mother? And why should I do what you want me to do anyway?"'*[9]

Some recall their mothers being directly influential. John H s mother worked in a variety of part-time office jobs and his father was a joiner with Glasgow Corporation.

John H: *'Mum is quite a sort of driving force. I think she decided I was going to be a doctor when I was a baby and I've resisted that right through until I actually had to fill in my form for university. Both of my parents have had a lot of influence in my life. My dad's a fairly placid guy with a wicked sense of humour and my mum's got quite a bit of drive. It was really my mum who I think got the family where it is today. I think they look on it as a big achievement to have two kids who are doctors, having come from a pretty poor background.'*[10]

Linda F s father was a welder and her mother worked as a lathe operator before taking part-time cleaning jobs. Linda attended a single-sex, fee-paying, school in Glasgow.

Linda F: *'My* [school] *friend's parents were doctors and I'm sure that's where it came from. I was back and forwards to their house all the time. Her eldest sister did dentistry and her brother did medicine, so it was all medicine talk.'*[11]

Others, like Colin R, were encouraged by schoolteachers to consider medicine as a career.

Colin R: *'*[I] *had no great ambition to be a doctor. But when I went to the careers master he said, 'Well, you've got a good group of Highers and you're not brilliant at anything, but you're OK across the board.' And he would suggest medicine or law, and I didn't fancy law — stupid me* [laughs]. [12]

Choosing general practice

During the World War II, Hector M was a senior house surgeon in the old Royal Alexander Infirmary, until 1 July 1944. He was waiting to be conscripted into the armed services.

Hector M: *'But I was told by the War Medical Committee that I would have to do some time in general practice. They were short of GPs and had plenty in the army at that time, so I was offered the choice of going to Caithness, Stornoway and somewhere equally outlandish or to Doctor Barr, 15 King Street, Paisley.'*[13]

Six years later Douglas H got his war when he served as a Regimental Medical Officer in Korea, Just general practice, but in a rougher circumstance . On leaving the army he found that:

' ....Beggars couldn't be choosers… Jobs were not hanging on trees. The last place I wanted to work in was Paisley, because my father was a minister in the town and it's not always a good thing. I could have been labelled just his son and not developed an identity of my own.'[14]

By the 1960s general practice was changing and the attitudes of entrants were changing too.

Robert B: *'I never saw general practice as being a place for failed surgeons or physicians, never… the new hospital consultants in Glasgow without question …* [would say], *'Oh, you're just a GP.'*[15]

Andrew K: *'I had my fellowship* [from Edinburgh] *and I had to decide what I was going to do… I applied for a post, a step up, in urology, which I didn't get because there was a lot of applicants… I had said to my wife at the time, 'If I don't get this post I am going to go into general practice.' That was really the decision. Looking back on it part of this was I don't want to bend at the knee. I don't like this hospital set up.'*[16]

Linda F: *'It was weird. I just suddenly thought, 'No, I don't think I really quite fancy this.' I could see all the backbiting and the backstabbing… You also saw how people used their contacts, their own personal family contacts in working out jobs and stuff like that. I realised I didn't actually have any of these footholds… But having said that, general practice* [in 1978] *was the primary choice.'*[17]

Christopher J: *'I've always had GP stamped on my bum… I'm independent-minded and bloody-minded and I hate being told what to do. I got the impression that in general practice you could really rule your own life.'*[18]

Later family influences

Peter V s first child was born in 1980, two years before going to general practice .

Peter V: *'I think when you're married — first of all it shapes your career. And then your mobility is severely limited by having children. If I hadn't been married and I hadn't had children my career would probably have been quite different. To take a research registrar's job was severely crippling financially and certainly one person can survive well, but not a family, you couldn't live on it, no.'*[19]

Eleanor H: *'My original reasons were that I wanted to do something that definitely involved patient contact. And I wanted a job where I would be using my medical diagnostic* [pause] *skills. I was engaged and I knew that I wanted to get married and wanted to have a family in due course. So, I want the kind of job where I can take a part-time commitment and at that stage there were no sort of part time medical jobs whatsoever.'*[20]

Postscript

Many years later some continue to keep their parents in mind.

Colin R.: *'I think … if this was my mother what would I want her doctor to do for her? And if it's good enough for my mother then it's good enough for your mother.'*[21]

'It is the mark of an educated man to look for precision in each class of things just so far as the nature of the subject admits; it is evidently equally foolish to accept probable reasoning from a mathematician and to demand from a rhetorician scientific proofs.'

(Aristotle, *Nicomachean Ethics*, 1094b23-28)

The Anvil

In his editorial 'Between the hammer and the anvil?', Iliffe[1] considers what he takes to be the two main problems confronting GPs. After some slight adjustment, we have agreed with this description but have offered a different solution — one that has its origins in Aristotle's ethics.[2] The hammer is the issue of decision-making with patients; the anvil is the problem of how to justly distribute moderately scarce resources. In what follows we consider this second problem and look specifically at the way in which an Aristotelian approach can address the problem of the 'Anvil'. This is territory traditionally associated with public health and health policy management. However, both directly in commissioning health care, and indirectly, through local health care co-operatives, GPs are increasingly involved in difficult decisions about allocating health care resources.

How should we approach this difficult area? The issues primarily concern distributive justice: in this case, the fairest or best way to distribute the limited amount of health care resources. The crunch, of course, comes when what is best for a patient is unavailable because of policy decisions about resource allocation. In short, the GP cannot do what he knows to be best because the resources needed have been directed elsewhere. These problems are taken to be particularly acute in the UK — no doubt partly because they are so. However, they are problems that are faced by all healthcare systems. The US, for instance, has very significant healthcare distribution problems, in spite of the fact that health expenditure is more than twice that of the UK.[3] The burgeoning discipline of health economics can help address these problems, but it is increasingly apparent that it is only a partial answer.[4]

It is commonly thought that a completed ethical/political theory would provide a blueprint for solving these problems. Indeed, we could turn to rights, liberties and principles (as the political liberal would) or to the greatest good for the greatest number (as the utilitarian would).[5] But it is far from obvious that a blueprint is what we need. In what follows we consider how an approach based on Aristotle's ethics might handle these issues.

Aristotle and the limits of precision

Aristotle thought that it was a mistake to demand more accuracy from a particular enquiry than the subject matter could provide (see the quotation above). The subject matter of ethics and politics, he thought, did not lend itself to theoretical accuracy. Although we can perhaps expect precision from science in its theory and prediction, the same is not true of ethics. This view follows from his claims about the nature of moral decision-making. His emphasis on particularity and context, on indefiniteness and indeterminacy and crucially, on the situational dependence of ethical judgement are all essentially tied to the business of making practical decisions. It is not surprising that a subject matter that requires this kind of decision-making also does not allow us theoretical precision.

The idea then, is that all moral decision-making, whether it is a clinical judgement or a policy decision about the allocation of resources, requires a special focus on the particularities of the context. Those faced with the decision need 'aisthesis' or situational appreciation'.[6]

Now the way in which this Aristotelian approach handles the hammer is fairly clear[2] but for the anvil, it is perhaps not so obvious. One might plausibly object in the following way:

'You say that decision-making can only be made in a specific context taking into account all features and depending on the perception of the deciders. However, in constructing laws, policies or guidelines, particularly with regard to the allocation/distribution of resources, precisely what is required are over-arching rules and generalisations across situations. So, while the approach may serve the GP in the clinical situation, it is precisely not what is required when it comes to the distribution of resources.'

The worry here is that when faced with particular patients, context sensitivity may well be the order of the day. But when faced with decisions that affect populations of people, what is needed *are* principles, guidelines and the very best general rules — just the kind of things that political liberals and utilitarians provide.

Acknowledging complexity

This objection is an important and understandable one but it fails to distinguish between the content of the decision and features of the decision-making itself. The content of the decision here is what the decision is about. This is to be distinguished from the actual process involved in making a decision. So, for example, whether a patient with a sore

References

1. Iliffe S. Between the hammer and the anvil? [Editorial.] *Br J Gen Pract* 2001; **51:** 700-701.
2. Gillies JCM, Sheehan MP. Practical reasoning and decision-making Hippocrates problem; Aristotle's answer. *Br J Gen Pract* 2002; **52:** 518-519.
3. Sheehan MP, Sheehan P.J. Justice and the social reality of health: the case of Australia. In: Rhodes R, Battin M, Silvers A (eds). *Health Care And Social Justice*. New York: Oxford University Press, (forthcoming).
4. Ubel, PA. *Pricing Life: Why it's Time for Health Care Rationing*. Cambridge, MA: MIT Press, 2000.
5. Roberts MJ, Reich MR. Ethical analysis in public health. *Lancet* 2002; **359:** 1055-1060.
6. Wiggins D. Deliberation and practical reason. In: Wiggins D. *Needs, Value, Truth*. (Third edition.). Oxford: Clarendon Press, 1998.
7. Toon P. *Towards a Philosophy of General Practice: a study of the virtuous practitioner.* [Occasional Paper 78.] London: Royal College of General Practitioners, 1999.
8. Jefferson T, Demicheli V, Mugford M. *Elementary Economic Evaluation in Health Care*. London: BMJ Publishing Group, 1996.

throat should be given aspirin or aspirin and penicillin is an issue concerning the content of a decision. The decision involves deciding between these two alternatives. However, whether or not a GP should take patients opinions about treatment into account is an issue about the way in which decisions are made (either good decision-making involves patients opinions or it does not).

The upshot of this is that the content of particular decisions can be as general as one likes without jeopardising the particularity of the decision-making. So, as with the GP s clinical decisions, policy or allocation decisions are particularistic. Because these decisions affect groups of people and their treatment, the content of each decision is general in this sense. However, since it is to be made by a particular group of policy-makers within a given set of financial constraints and to affect a certain community, the decision remains a decision in a particular context (see example). Although the scope and effect of policy decisions is vastly different from those of individual clinical judgments, the way in which such decisions are made can still be dependent upon features relevant to the particular context and independent of rules and principles (except when used as rules of thumb).[2]

One of the distinctive features of Aristotle s ethics is his focus on the individual agent rather than on principles governing what ought to be done. This focus is at work here and is an important backdrop to these issues about decision-making. The concern with the agent (whether the GP or the policy-maker) is reflected in the concern about how decisions are made. What matters is that those responsible for allocating resources see and reflect on *all* of the particularities of the decision-making context.

Our claim is that the complexity and difficulty of resource allocation decisions mirrors that of clinical decisions. Though they have different scope and effect, they still require a kind of situational appreciation that is born of experience, consideration and reflection. As more GPs become involved in decisions about resource allocation, we are confident that the difficulty of these decisions will be more widely understood and that better decisions will be made as a result of this. In the meantime, we certainly should require those who are responsible for the allocation of resources to explain and justify their decisions and we should lobby, where possible, to increase the pool of resources to be allocated. However, we should do so with the knowledge that such decisions are irreducibly complex and difficult.

Example

Consider, for example, a health organisation that has new recurrent funding of £1 000 000 per year to spend. A wide-ranging needs assessment reduces the possibilities for this spending to three. They are:

(a) a new sexual health service for teenagers, among whom there is a high rate of unintended (and terminated) pregnancies;
(b) a drive to reduce the waiting time for total hip replacements (currently standing at twelve months); and,
(c) an increase in numbers of practice nurses to improve the care of patients with chronic diseases like chronic obstructive pulmonary disease, diabetes, and heart disease (currently regarded as poor).

So how should the decision be made? Are there theories that can tell us what to do? Health economics, for instance, aims to 'facilitate decisions about how resources are best used'.[8] It is true that the principle of measurement can help to estimate numbers of individuals who may be helped by the three options. Units like the quality-adjusted life year (QALY)[7] can provide a crude proxy measure for health gain.

However, the interventions, in this case, have very different outcomes. In (a) there are fewer unintended teenage pregnancies, in (b) there is less time in pain for those waiting for hip joints, and in (c) there are fewer heart attacks, strokes and hospital admissions among those with heart disease, COPD or diabetes. One cannot compare interventions when they result in more completed educational years and fewer terminations of pregnancy, more mobility for elderly people with opportunities to enjoy holidays abroad and play with grandchildren, and fewer deaths and less lasting disability for patients with enduring illnesses. So, while health economics may provide some useful information, it encounters the problem of incommensurability — of outcomes that cannot be compared by a common measure.

Making the right decision, be it policy or clinical, does not depend on having a worked-out theory of ethics; it requires an understanding of all the elements of the local, particular situation. It requires experience, reflection, deliberation and situational appreciation.

Key Points

GPs are increasingly involved with decisions about the allocation of resources.
As with clinical decisions, resource allocation decisions are complex and particular.

Even though the content of resource allocation decisions is very different from that of clinical decisions, the way in which they should be made is similar.

An approach based on Aristotle s ethics, again in these cases, stresses the role of situational appreciation in the assessment of a decision-making situation.

It is a mistake to expect theory, rules or guidelines to solve these problems. This would be to require more precision than the subject matter permits.

Mark P Sheehan
John CM Gillies

We are not alone. GPs all over Europe, all over the world, are unhappy, over-regulated, under-valued, misunderstood, patronised, in the grip of forces beyond their control, short of young colleagues, yet at the same time deeply convinced that they are doing one of the most important and richly rewarding jobs that life has to offer. They are also convinced that the special quality of general practice, its engagement with the mystery inherent in human life, is highly vulnerable to the contemporary orthodoxy of mechanistic science.

To seek to summarise such a vast conference 2000 delegates from 31 countries, 750 presentations, comprising plenary addresses, up to 17 simultaneous sessions, poster displays is perhaps absurd, but this strong theme emerged from the chill mists and hail-storms of football-fixated high summer in Parliament square.

Martyn Evans, (UK): the GP can play a starring role ... getting to see the undiagnosed patient as a whole ... the first and finest defence against over-mechanised medicine practising a richer and more sensitive medicine ... beyond the reach of science .

Carl Rudebeck (Sweden): Understanding a text, or a patient, is not a purely logical matter Intuition is beyond doubt and beyond evidence. It is in itself evident .

Heinz-Harald Abholz (Germany): Comprehensiveness and continuity of care are core values necessary for the survival of German general practice we must sell the concept of generalism as a speciality to politicians .

Carol Herbert (Canada): family physicians, not least in North America, have been giving up medical services that a well-trained family physician can deliver, e.g. maternity care, office surgery, or care of the dying if we become restricted service physicians medical technicians who provide episodic care for common illnesses by algorithm , nine-to-fivers, docs in a box, to patients we do not know, it can be argued that there will be no discipline of general practice to research .

John Adams (UK): risk-taking is a necessary part of life the current attempt to eliminate risk is a creeping madness .

Britain, freely acknowledged by the visitors to be the birthplace of modern general practice, has hosted a fine conference. It was too expensive, and WONCA cringes under its ridiculous name. But the venue was magnificent and the programme superb. Finding trends to be worldwide and not merely of the NHS is hugely strengthening. If the GPs of the world can speak with this unity about issues of universal concern there is a better chance they will be heeded.

James Willis

I first learned of the Royal College of General Practitioners when I was training in the US, through its morbidity reporting tools. Ever since I have held it in high regard because of its fidelity to improving primary care. Thus, I was drawn to the day-long seminar celebrating its 50th anniversary.

The day s presentations made obvious the debt family doctors and patients owe the RCGP. The College exposed the role of the family doctor not only in the UK, but also in countries without doctors positioned to take care of most people most of the time. The College fuelled training for the specific challenges of family doctoring and inspired research by developing journals, taxonomies, and epidemiological reports. This history came alive in the words and personalities in the room. Powerful, old and nascent ideas, held by old and young family doctors, not necessarily in that order, abounded. Like a voyeur from afar, I peered into these sessions and felt a pervasive sense that despite years of success, general practice in the UK is in trouble, admitted to be coming apart .

Perversely, I took comfort in learning that the chaos I experience in my US practice is also occurring in the UK, with its venerable history and traditions. Indeed, the redesign for fuller realisation of family practice in the information age is a worldwide event. The Brits and the RCGP are now one among many in a position to make a substantial contribution to achieving the enduring aspirations of family doctors while optimising practice with new ideas and technologies.

I departed certain that family practice no longer belongs to those who invented it, but to those who can make it become care that is first, foremost, and fundamental for people.

Larry Green

We ve had a great week meeting delegates from all over the world at an amazing venue with fantastic views of Westminster Abbey.

Many people seem to be interested in working overseas and have learnt about the opportunities VSO placements offer GPs and other health professionals.

So many people visited the VSO stand and bought raffle tickets and T-shirts for their children, that we will be able to fund some more primary health care volunteers in

developing countries.

VSO is privileged to have been at WONCA Europe 2002 this week and had such an excellent opportunity to promote our activities.

Congratulations to the RCGP on its 50th anniversary and for hosting such an enjoyable and successful conference. Even the dreadful weather hasn t dampened spirits here.

Thank you all for your support over the past week here at Wonca in Westminster.

From all at VSO (Voluntary Service Overseas). **www.vso.org.uk**

THE red, white and blue logo blobs of the London WONCA Europe conference guided roughly 2000 delegates from many corners of Europe including honorary Europeans (Australians) around the Queen Elizabeth II Centre, which squats alongside the resplendent houses of Parliament and Westminster Abbey. It was, as the Irish would say, a grand affair. The meeting will live in my memory for having crystallised the existential anxieties of generalist practitioners.

The voluminous togetherness of the early morning plenaries helped bind the event and put the circulating ideas into a communal melting pot that could be debated over the amazing wealth of other workshops, oral presentations, and poster rotations. The key speakers Martyn Evans and Carl Rudebeck, pointed up the importance of the personal, the human, the continuous, to value our diagnostic intuition and the added insights that the enduring patient practitioner relationships provide in primary care. Sentiments that somehow needed re-enforcement, a reaction perhaps to the exhortations to guideline-follow-quality-improve, a performance management agenda that seem to be emblematic of the way we should now work , although, as it seems at least, without any new resources. Carol Herbert, a primary care clinician and University dean in Western Ontario, outlined the teenager status of the research agenda: self-conscious and struggling to break out of pocket-money mode.

Over-booked sessions were those on doctor burnout and the definitions of core competences of general practice. Could this reflect a quiet if real sense of concern, as policy seems to drive the generalist towards degrees of specialisation, embrace triage and role substitution? Add to this heady mix the interest in how to achieve Continuous Professional Development that achieves a balance between wishes and needs, and how to pluck out rotten apples without tipping the entire wheelbarrow, and you get an idea of the debates that occurred. Finally, bring in the halogen glare of technological developments PDAs, information portals, interactive patient websites and virtual electronic patient records and you rapidly get the impression that primary care is arriving at many crossroads, almost simultaneously. And a sense of what it was like to WONCA in London.

Glyn Elwyn

WONCA Europe 2002 has lived up to expectations: thought provoking lectures, exhilarating workshops and warm company. The four plenary lectures set the tone.

Martyn Evans addressed the philosophy of wonder . He pleaded with us to reflect on the wonder of our own existence, our experiences, and that of our patients. When all around are stressed and suffering, Dr Evans implored us to discover the wonderful things about the patient before us. Dwelling on wonders, even for a short while, can be empowering.

In the following day s lecture, Carl Rudebeck went further. The message he was sending concerned imagination and empathy . Sit back at the next consultation and try to imagine what your patient experiences at home, work, at play. There is more to her presentation than the physical symptoms. Through common understanding we can hope to achieve better idea of her condition.

Carol Herbert focused on expanding the research base of general practice and family medicine. It is certainly an uphill task in many countries, but steady progress is occurring. This issue was addressed in many of the workshops and oral presentations.

Lastly, Professor John Adams gave a *tour de force* concerning risk management and injidents (injury-producing accidents). Check out **www.geog.ucl.ac.uk/safety/risk** for an overview with detailed examples.

Magic moment: Danish delegate to a group of Spaniards, French and English bemoaning the lack of a common language for Europe in English!

David Lewis

As a final year medical student and aspiring GP, I was delighted to attend the WONCA Europe 2002 conference. Right from the start I began meeting people whose names were familiar as the visionary thinkers and political leaders in general practice. Not at all the distant God-like figures I had expected, and welcoming me into their exciting community. An almost childlike sense of wonder for life and medicine.

This atmosphere was sustained throughout the conference. The big questions were asked and debated What is medicine for? , and Where is it going? in lectures, workshops and informal discussion. Practical matters were discussed too, such as WONCA s new European Definition of General Practice/Family Medicine, which will be a useful tool to guide my future learning. There was talk of consumerism overthrowing the traditional values of medicine, but I came away with a powerful conviction that resistance will be possible.

Now at the end of the conference, my greatest ambition to join the ranks of general practitioners has only intensified. I will feel unbelieveably privileged if I can get there a few years from now; and I am more convinced than ever before that general practice is the essence of what doctoring is all about.

Graeme Walker

THIS was my first time at WONCA, and from previous descriptions I wasn t expecting a lot. I was pleasantly surprised. This was one of the most interesting and stimulating conferences I have been to.

I stuck to sessions with multiple presentations much the best plan in my opinion. They were varied, and if one speaker disappointed then another would delight. If only there had been more time for questions; some chairs were good time keepers, but most were not.

While the content of the sessions was good, the debates between them were better; coffee queues and sandwich lunches inspired thought-provoking discussions. What became clear was the gap between those that espouse managed care (the cookbook medicine brigade) and those that find virtue only in patient-centred care (the touchy-feely groupies). The challenge for organisations such as WONCA and the RCGP is to bring together these two positions they re both right, so over the next decade we need to find out how they can co-exist.

One major criticism: cost. This effectively meant this conference was open only to those who were paid for by someone else; it was lacking in grassroot GPs, nurses, and managers. How can such a well organised and impressive conference run at a lower cost to delegates? Come on WONCA, make it affordable next time.

Tim Wilson

Heroin Century
Tom Carnwath and Ian Smith
Routledge, 2002,
PB, 216pp, £14.99, 0 41527899 6

HEROIN has been in the news a good deal lately. The Home Affairs Committee recently produced its long awaited report where its use and abuse was discussed rather extensively. Heroin is highly addictive and its illegality means that the addiction is difficult to satisfy safely. It is this dependence and its illegality that causes users to engage in a cycle of high risk and damaging behaviour to obtain the heroin they depend on. The problems associated with heroin use are multifold and include HIV/AIDS, overdose and death, and malnutrition, to name a few. However, many of these are secondary or confounders, and judiciously used, heroin has few dangers. Certainly, used correctly without needle sharing the user can enjoy a life free from the side effects we typical associate with the junkie sleeping outside London s Leicester Square tube station. Some feel that full legalisation of the drug is the only way of dealing with the misery it causes. Others think that heroin should be provided on the NHS to prevent illicit sources that require crime to fund. Protagonists of this approach argue that giving drug users the heroin they crave for commits them to lifelong addiction, supported by the state; after all, why stop if you can get it for free for the rest of your days.

The heroin trials in Switzerland and the Netherlands do not really add much, it is always dangerous to extrapolate the results of a well-controlled, well-resourced study with a cash-starved, people-starved NHS in the real world. Also, supervising injecting up to four times a day cannot be conducive to normal living.

So the debate around heroin continues, and heroin is particularly good at inducing opposing opinions, many of which conflict with the evidence. So how can we take part in the debate? How as doctors can we be sure of the way ahead? Certainly becoming better informed is to read the book *Heroin Century*.

If you read no other book on drug misuse, read this one. It is informative with thousands of references, up to date, including a discussion on the effects of the 11 September incident on world heroin supplies, but above all this book is a great read. It s not like reading a textbook, more like reading a novel where the heroine is heroin. We follow the movements of our heroine from the Bunsen burner in St Mary s Hospital to the poppy fields of Afghanistan. We follow the pain and sorrow our heroine brings but also the intense ecstasy and orgasmic joy that precedes this pain.

Along the way we explode a few myths; perhaps my favourite is the assertion that heroin aids creativity, the reply to which quoted in the book from Musician Chris Starling reads If you re a twat and you take heroin, you ll be a twat who s taken heroin. But if you re a really good guitar player and you take heroin you might be late for a rehearsal, but you ll still be a good guitar player.

The book guides us through the history of heroin, from the soothing agent and general mother s help in Victorian days, through the use as a cure for morphine addiction between the Wars to the current bed-sitter use of today. This is an intelligent book that requires intelligent reading. For example, it takes us through a complicated debate about whether the link between heroin use and criminality is as strong as we are led to believe.

Another chapter deals with the myth of dependence and that many people use heroin in a controlled fashion and that lifelong heroin use is compatible with a healthy and productive life, the authors quoting, I am afraid, Dr Clive Froggett as an example to prove the point.

The book aims to provide a dispassionate and objective review of heroin since its introduction to medicine almost a century ago. A review certainly is what we get. Dispassionate? Definitely not. Objective? Well, you judge. After all how can one be completely objective about a substance that, to quote Thomas DeQuincy when he first used it: Here was a panacea for all human woes; here was the secret of happiness, about which philosophers have disputed for so many ages, at once discovered: happiness might now be bought for a penny, and carried in the waistcoat pocket: portable ecstasies might be had corked up in a pint bottle: and peace of mind could be sent down in gallons by the mail coach. Or as a doctor in Hong Kong making the drug claimed heroin unanimously the best medicine in the World .

Read this book at very least you will be informed but at most you will be greatly entertained.

Clare Gerada

Evidence-based Patient Choice inevitable or impossible?
Edited by Adrian Edwards and Glyn Elwyn
Oxford 2001, PB, 331pp, £19.95, 0 19263194 2

Shared Decision Making Patient Involvement in Clinical Practice
WOK, Nijmegen 2001, PB, 221pp, 90 7631612 0

TEN years ago, the archetypal heartsink consultation was with a GRT (*Guardian*-reading teacher). Today s equivalent of *The Guardian* is the Internet print-out. Our stereotype resents the presumption of these individuals, who dare to seek information about their symptoms prior to attendance, rather than trust ours. If we are being honest, however, we feel threatened by the encroachment into our territory, with the erosion of our unique access to medical knowledge. The traditional model of powerful doctor and meek patient is increasingly difficult to apply (fortunately). A more current model, in which doctor and patient are equal partners, has been proposed,[1,2] with the each bringing a different perspective on knowledge of the condition. Others, however, see this as harmful and, ultimately, destructive.[3] There is probably truth in both of these extremes, and much depends on the validity of the two sources of knowledge, and their ability to converge and advance.

Evidence-based patient choice (EBPC) is one term given to this concept, outlined in the first of these books. It is, as the editors admit, a clumsy term, but it is difficult to find another more suitable. It developed from the old dinosaur that was evidence-based medicine (EBM) and represents an appropriate evolution. While EBM required doctors to base our decisions on the best available scientific evidence , EBPC recognises that this is only one part of the story, and allows the influence of many other factors important to our patients. This is a much greater challenge, calling for wider epidemiology, the development of new theories to guide decision making and its measurement, new skills and attitudes in striving for concordance, and new methods of disseminating valid information to doctors and patients to inform decisions. This book provides a current review of the literature, followed by practical approaches to implementation. The second book, which is a doctoral thesis, describes an elegant and innovative programme of research investigating the theoretical base of EBPC.

The first book is based on the assumption that patient choice is a Good Thing, and that more is required. Sensibly, it begins with a review of the ethics, acknowledging that mandatory patient autonomy can be as harmful an extreme as paternalism, concluding that shared decision making represents the correct middle ground. This seems intuitively correct to us as GPs. We are then led through some of the background required to enable us to inhabit this middle ground in an evidence-based way. This includes useful chapters on health economics (much of which is about measuring patient preference) and communication of risk to patients a particular challenge, in view of the prevailing epidemiological illiteracy. We remember, at the height of the bovine spongiform encephalitis scare in the UK, the untouched supermarket shelves of beef contrasting with the long queues at the cigarette counter.

Some assumptions irritate the medical reader, who is perceived to be incapable at present. We are told that evidence-based health care is iconoclastic , which may often be true, but implies a desire to ruffle feathers rather than to provide best care (which, in certain instances, we may already be doing). We are then told that the patient-centred model of care requires a shift in the mind-set of the clinician (whoever he or she may be). I thought I was already doing it, and this was confirmed by the chapter, written by an epidemiologist and a social worker, which tells me how I should be consulting. More sympathetic and practical examples are provided later on, in chapters on EBPC in primary care and in secondary care, the latter (by Rosenberg) particularly helpful. Our own Trish Greenhalgh puts in an appearance in which she guides us through a hypothetical clinical case, illustrating EBPC, through narrative-based medicine . Unfortunately, I feel that she has fallen into the trap that Rosenberg has climbed out of. The case that she describes is seductive in its process, ideals and outcome, but so intensive of time and effort that its widespread parallel would be prohibitive to all but the workaholic. Okay for her, then, but not for our more mortal colleagues.

Reading the book, one recognises several objections to EBPC, including a lack of available evidence for many decisions, practical resource implications in accessing this evidence, information and technology to back decision-making discussions, and difficulties when the patient s choice is too expensive, not effective, or not available. MMR single vaccines, and PSA screening are two current examples. Each of these objections is addressed to some extent, and, although this is mostly near the end, I was left with the impression of a treatise that had been thoroughly considered. The book is targeted at every medical professional in practice or in training . If this is true, these problems could be more persuasively dealt with earlier on, allowing the reader to read the remainder more sympathetically. EBPC is a discipline in its infancy. This book describes the science that has shaped it so far, and notes the gaps in the evidence that will need to be filled in if it is to mature.

Blair Smith

References
1. Coulter A. After Bristol: putting patients at the centre. *BMJ* 2002; **324:** 648-51.
2. Smith R. The discomfort of patient power. *BMJ* 2002; **324:** 497-498.
3. McQueen D. Patients are not doctors equals. *BMJ* 2002; **324:** 1214.

http://www.dynamicmedical.com/ is a US-based website providing a database of primary care clinical information on over 1600 conditions. For me, it scores over GPnotebook (Back Pages, May 2002 page 437) because of the breadth and depth of information provided and the hyperlinks to other resources, e.g. Cochrane reviews, original papers or patient information leaflets.

On seeing a patient with Osgood Schlatters disease, Dynamed helped me confirm the diagnosis, outline the management, and provide an information leaflet. Each review allows one to comment on it and enter a dialogue with the author and other users. The main disadvantage from a UK perspective is the North American bias, especially on drug information and patient leaflets. Also, the initial registration is rather slow.

Since April this year it has ceased to be completely free. However, it does offer an open source model with an option to subscribe through effort , as well as conventional paid subscription. If you agree to be a peer reviewer then you can gain free access, so allowing Dynamed to retain independence from pharma or other vested interests.

There is a free month s trial before having to commit to one of these options. Why not give it a go?

Alan Shirley

Manchester Art Gallery
Mosley Street, Manchester M2 3JL. Tel: 0161 235 8888; Fax: 0161 235 8899
Minicom: 0161 235 8893

Tuesday–Sunday 10.00am–5.00pm
Closed Mondays except Bank Holidays.

If you are looking for a family day out this summer you could do a lot worse than Manchester. With the upcoming openings of the Urbis Museum of the Modern City and the Imperial War Museum North, not to mention the 2002 Commonwealth Games, you would think Manchester had plenty to offer already. Manchester City Art Gallery was re-launched this week after a four-year, £35 million refurbishment project. It is now twice the size and, it is hoped, twice the fun.

The rather austere Victorian building, built in the Greek revival style, has been linked to the neighbouring Athenaeum by way of a glass atrium. Designed by Sir Michael Hopkins, the new extension has brought the Gallery into the 21st century, with its simple minimalist style softened by the use of sandblasted glass and gauze. The galleries have a light and airy feel and the freshly painted white walls provide clarity and space for the works of art displayed on them.

The Gallery s permanent collection is dominated by the Pre-Raphaelite paintings of William Holman Hunt, Ford Maddox Brown and Dante Gabriel Rossetti. There are 18th century masters including Gainsborough and Turner, as well as classic pieces such as Constable s View from Hampstead Heath . The more contemporary collections feature the work of Francis Bacon and Lucien Freud. There is also an example of early Pop Art in Hockney s Peter C . However, with only one or sometimes two paintings by each of the major artists some have criticised the collection for a lack of continuity and its failure to focus on particular names or movements in art. This misses the point of the Gallery s new ethos. Manchester Art Gallery aims to be family-friendly and to draw in the crowds in the face of national trends of falling attendance. It does this by showcasing works right across the artistic spectrum and by providing a number of ways for the public to feel more involved. There are a range of audio guides available, including one designed especially for children and narrated by children s author Terry Jones. However, the highlight for most children (and many adults!) is the interactive gallery where an electronic chariot racing game brings to life Alexander Von Wagner s The Chariot Race and where ring master dressing-up costumes are provided in both child and adult sizes.

While there may not be much of any one thing, the sheer variety of works on display in Manchester means there truly is something for everyone.

Helena Wilton

The Bacchai
National Theatre, London

All of Peter Hall s Greek Tragedies have provoked controversy over his passion for the mask as a theatrical tool. His critics say that by using masks he sacrifices content for form. Yet his current production of the Bacchai is a triumph for the mask.

The masks are its most striking feature. At first they are off-putting, making the actors voices sound gutteral. Gradually, one relaxes into the performance and the masks intensify the drama. The climax is a mother s heart-rending grief as she realises she has murdered her son. Such grief played without a mask would alienate the audience. Its extremity would repulse. The drama conducted behind masks and offstage allows us to feel the emotion undistracted by real blood and tears.

Most gentle and most terrible, was how Euripides describes Dionysus. A paradox, a god of wine, theatre, madness. A god of blissful ecstacy and here of savage terror. He pits himself against Pentheus, the King of Thebes, and the established order in the name of hedonism.

The women of Thebes, including Pentheus mother, Agave, have been seduced by Dionysus in earthly guise to join his female followers, the Bacchai, living in a nearby forest in brutish debauchery. Threatening the stability of the city and his authority, Pentheus declares war on their leader.

Greg Hicks, as Dionysus, is a sensuous, raw physical presence. He delivers a glorious performance which is in turns both camp and macho. At his best he flatters and coaxes Pentheus toward his certain death at the hands of the Bacchai. The spellbound Pentheus relishes his transvestism, disguised as one of them to infiltrate their number.

In the wittiest of theatrical conjuring tricks William Huston plays both Pentheus and his murderous mother. Victim and assassin, male and female played with equal surity.

All the most dramatic moments are intensified by Harrison Birtwhistle s spare, pulsating music. His score is a bonus to the production. Not quite such a bonus was the moment of high camp when finally Dionysus is raised above the stage, glittering with gold to give his admonishments before descending beneath the stage.

The staging, by Alison Chitty, is minimalist with a bare arena which splits in half with flames during the sacking of Thebes.

All in all there was little in the way of props. But a captivated audience needed no more for two hours than three men, a chorus, some masks and a tragic tale.

Julie Sharman

5th WONCA Conference on Rural Health, Melbourne

THE year 2002 is the 30th birthday of WONCA, the World Organization of Family Doctors, and the 5th WONCA Conference on Rural Health in Melbourne (30 April to 3 May), demonstrated the important role that the organisation plays in the development of general practice worldwide.

In the days immediately preceding and following the Conference, there were opportunities for delegates to attend events at locations around Australia, to discuss key rural health issues. A particularly memorable event was a Community Based Medical Education Study Tour in the Riverland area of South Australia, where senior medical students at Flinders University are able to study for an entire clinical year in rural general practice. With delegates from New Mexico, Canada, Australia, Liverpool and Sussex, recent developments and experience in CBME were discussed while delegates travelled along the River Murrey by houseboat.

The main WONCA Conference adopted the theme Working Together: Communities, Professions, Services . Keynote speakers from around the world emphasised the importance of health professionals, service providers, and local communities working together in partnership to improve health outcomes for rural people. James Fitzpatrick, Medical Student and Young Australian of the Year 2001, gave a thrilling presentation on the role of medical students in encouraging young rural people to contribute to the development of their communities.

In addition, daily symposia on key issues, and over 150 free-standing papers were available to choose from during the main three days of the conference. Delegates had the chance to attend clinical skills sessions in emergency medicine, breakfast and lunchtime sessions, and to view nearly 100 posters, and on the final day the Melbourne Manifesto, the product of the conference, was launched.

The Conference presented an opportunity to develop relationships with other rural doctors from around the world during a social programme that included Australian bush dancing and barbecue, and the Conference dinner where we celebrated 30 years of WONCA and learnt about its origins and history.

This was an excellent conference that covered a range of rural health issues. One of the important aspects of the rural health movement is that we face many common issues wherever we live and work. There is a growing sense of a global rural health community. Details of the academic programme together with abstracts and full text of some of the papers are available on the conference websites **www.ruralhealth 2002.net** and **http:// abc.net.au/rural/world health/default.htm**

Andrew Thornett

roger neighbour – behind the lines

On bititulism

When did you last see a book with a proper title? OK, let s narrow it down a bit a medical book with a simple crisp one-liner on the cover, in the tradition of William Harvey s classic *Exercitatio anatomica de motu cordis et sanguinis in animalibus*. One searches in vain for *Harry Potter and the Sheffield prosthesis*, or *Everything you needed to know about Class II National Insurance contributions but were afraid to ask*?

Nowadays every book seems to have two titles. The main one is short and (in the publishers eyes at least) catchy, and Each Word Has An Initial Capital. Then there s a colon. Then, post-colonically, you get the subtitle, in lower case and considerably longer. Were modesty not to forbid, I could cite *The Inner Consultation: how to develop an effective and intuitive consulting style*. Even as I write, the *BMJ* carries a review of John Bunker s *Medicine Matters After All: measuring the benefits of medical care, a healthy lifestyle, and a just social environment*.

What s going on here? Is this bititulism a form of inverted familiarity, the opposite of My name s The Honourable Hector Arbuthnot-Smythe, but you can call me Snubby ? Maybe it s a sign of affluence the two-car family preferring two-title books. Or a reflection of the tabloid/broadsheet split in our mass media Gotcha! versus 368 feared lost as General Belgrano is sunk .

This Grab em by the nose then lead em where you will technique is the stock-in-trade of professional manipulators like hypnotists and advertising executives. So when politicians start doing it we should get nervous. Bititulism is now ubiquitous in the committee rooms of power. Remember the gloved fist of *Developing NHS Purchasing & GP Fundholding: towards a primary care-led NHS*, or the wittily-named *A Short Cut To Better Services: day surgery in England and Wales*? The latest example is the motherhood-and-apple-pie of *The NHS Plan: a plan for investment, a plan for reform*. Do you spot the theme? *Political Bititulism: a sound-bite and a follow-up platitude*.

You d think we d have learned by now; the point of such rhetorical tricks is to obfuscate with spurious sincerity. Two-part inventions like these are intended to soften us up so that, bleary-eyed with The Vision Thing, we don t notice the quicksand into which we are being enticed. *Two-Part Titles: a strategy for securing mindless acquiescence*.

Worse, bititulism has spawned an epidemic of banality in the form of a proliferation of cringe-making mission statements that so disfigure the thinking (or at least the letterheads) of our national institutions. You know the sort of thing: *Council Finance Office: balancing books for a better Bogthorpe,* or *The National Consortium of Double Glazing Salespersons: serving you right*. Closer to home we have the GMC, now *'Protecting patients, guiding doctors'*. Even the RCGP, no longer content with *Cum scientia caritas*, has dredged up *Promoting excellence in family medicine'*. At least with the Latin, you knew what it meant.

I think somewhere there must be either a committee or a small plastic gizmo whose function is to generate this rubbish. It s easy enough you start with an aspirational phrase such as towards or striving for . Follow it with some desirable-sounding and politically correct abstraction fairness, perhaps, or service and round it off with a phrase suggesting universality, e.g., in general practice or for the new millennium . The result is a slogan implying that we, like the Soviet comrades of old, are drones with fixed dilated grins marching in step behind the dictator s tawdry flag. *Mission Statements: jingoistic gibberish for the gullible*.

Fun though it may be to laugh at the more outlandish examples of bititulism, or to think up one s own *The Royal College of Midwives: pushing for progress in parturition?* I have a serious purpose in lampooning it. Two purposes, actually.

First, there is a danger that, by taking mission-statementism seriously, we fail to recognise the extreme of self-parody into which we may fall. By reducing a genuinely noble ambition to a silly slogan we risk (baby and bath-water-wise) allowing ourselves to abandon it. The mission statement cheapens the mission. The big pictures that ought to concern us the well-being of individuals and the health of the nation are too complex to be reduced to small-minded catch phrases.

Secondly, we should not shrink from denouncing the prevailing culture of oversimplification, nor from questioning the motives of our political masters who would have us subscribe to it. Whenever we see a two-part heading to a political initiative we should publicly and vociferously add a third its real subtext. *The NHS plan: a plan for investment, a plan for reform — doctors, do as the Government tells you or go hungry. The RCGP: promoting excellence in family medicine — against all the odds.*

RCGP/Boots Research Paper of the Year

Acknowledgements
The College thanks Boots the Chemists for their generous support for both the award and the Research Seminar held on 21 May 2002 at which the winners of the prize presented their findings. Thanks are also due to the eleven panelists who gave their time to judge the entries, to the researchers who agreed that their papers could be submitted to rigorous peer review, and to Fenny Green for administering the award with great patience and expertise.

Although Boots the Chemists sponsor the award, all decisions about the award are made independently, reflecting the collective decision by the panel of assessors.

RESEARCHERS in primary care face many challenges, including limited time, capacity and resources. They can also feel undervalued by their peers, or by colleagues working in other parts of the NHS or academia. The RCGP/Boots the Chemists Research Paper of the Year provides an important opportunity to redress this problem by recognising, emphasising and celebrating research within general practice. It provides a visible statement about the quality of work taking place in general practice and primary care. It may also provide a mechanism for encouraging more practitioners to become involved in research, whatever their professional background.

Nominations for the award can be made by anyone and there is no restriction on the subject matter. The research, however, must have been undertaken in the United Kingdom and must be relevant to general practice. At least one author must have been an active GP undertaking clinical duties when the work was done. Each paper is judged in terms of its originality, applicability, contribution to the standing of general practice or primary care, and presentation. Each entry is assessed by a panel of referees representing a number of key stakeholders in primary care research, including patients, the Medical Research Council, postgraduate education, university academic departments and academic journals.

Thirty-five entries were received this year, of which ten were shortlisted by the panel. The quality of submissions was almost universally high. A wide range of clinical subjects were covered: back pain, bereavement, childhood cancer, chronic fatigue, chronic pelvic pain, heart disease, hypertension, immunisation, mental health, respiratory disease and smoking cessation. Other topics researched included measuring clinical governance performance, the doctor patient relationship, the feasibility of implementing guidelines, GPs care of their own health, learning styles, managing patient demand, patients attitudes to chaperones and teenagers views of primary care. The full range of methodological approaches was represented: qualitative studies, randomised trials, cross-sectional, case-control and cohort studies. As in previous years, most papers were published in the *British Journal of General Practice* (16 papers), followed by the *British Medical Journal* (12 papers), *the Lancet* (three papers), and another four journals.

This years winner was influences on hospital admission for asthma in south Asian and white adults: qualitative interview study by Griffiths *et al*[1]. This multi-disciplinary team from London interviewed 59 south Asian and white adults with asthma (49 of whom had been admitted to hospital with asthma), 17 GPs, five accident and emergency doctors, two out-of-hours GPs and one asthma specialist nurse. Views were sought about influences on admission, events leading to admission, general practices organisation and asthma strategies, the doctor patient relationship and cultural attitudes to asthma. The two patient groups coped differently with their illness. South Asians were less confident in controlling their asthma, were unfamiliar with the concept of preventive medication, often expressed less confidence in their GP and managed exacerbations with family advocacy without systematic changes to prophylaxis or oral steroids. Patients describing difficulty accessing primary care during exacerbations were registered with practices with weak asthma care strategies. Patients describing easy access to care seemed to have partnerships with their GP, were more confident about controlling their asthma and were registered with practices with well developed asthma strategies.

The paper provided a powerful reminder that, at a time when judgements about quality in general practice are in danger of being reduced to biomedical dimensions, judgements about goodness also need to consider cultural issues related to patients, and organisational factors associated with disadvantage and practice structure. Not only are the findings of direct relevance to practitioners providing care, these should also inform managers involved in developing and monitoring health care services.

Primary care research is seriously under-resourced, severely hampering its ability to deliver answers to fundamental issues facing practitioners wishing to provide optimal care for their patients. Even so, excellent research is being undertaken. The RCGP/Boots the Chemists Research Paper of the Year provides a valuable forum for highlighting this fact. It is very pleasing, therefore, to announce that Boots the Chemists have agreed to continue its sponsorship of the award for another three years.

Entries for the year 2002 Research Paper of the Year award are currently being invited. The closing date is Friday, 17 January 2003. Entries may be sent to Fenny Green at RCGP, Princes Gate, at any time up till the closing date. Information on how to submit an entry is available at ***http://www.rcgp.org.uk/rcgp/research/paperoftheyear/index.asp##2000*** *or by contacting the Research Office at the RCGP.*

Phil Hanniford

Reference
Griffiths C, Kaur G, Gantley M, Hillier S, Goddard J, Packe G. Influences on hospital admission for asthma in south Asian and white adults: qualitative interview study. *BMJ* 2001; **323:** 962-966.

The *BJGP* in 2001

We have undertaken to publish annually some data describing our performance against criteria published on the website. Mostly these deal with speed of response, since this is one of the loudest criticisms levelled at the journal by authors. We considered the data at the Editorial Board meeting in April.

The total number of submissions in 2001 was 571. We were all surprised that this should have dropped from 622 in 2000 and a high of 705 in 1999, but none of us know whether it is a long term trend or something cyclical related to the timetable for the Universities Research Assessment Exercise. Since the total acceptance rate of papers is only 16% (21% if we include letters originally submitted as papers) it seems pointless to worry about it. The majority of submissions continue to come from the UK (74%, compared with 81% in 2000). Academic departments of primary care submit 41% of the total, more than any other category.

At the corresponding meeting the previous year, we were specifically asked to improve our initial response time and try to reject more papers before peer review. Here we were happy to report significant change. Last year we rejected 19% of papers without sending them for peer review, compared with only 6% the previous year. This may seem like summary justice but the Board s strongly held view is that a quick rejection is better than a slow one. Also we don t want to ask hard-pressed reviewers to spend time refereeing a paper that we know we shall not want to publish. The loss of feedback to authors on such papers is, we feel, an acceptable price to pay. As far as time is concerned, last year we did respond to 80% of authors within the target of three months, with a median of 76 days (IQR 54 to 89). Again this is a considerable improvement on the 63% of the previous year, and the figures look only slightly worse if those rejected before peer review are excluded from the analysis. At the same time we have noticed (as will many readers have done) that the delay from final acceptance to publication has become unacceptably long and we are going to have to address this in the future.

Finally appeals. We discussed the procedure for appealing and confirmed the statement on the website. They cause quite a bit of work for Board members, but the procedure is essential since we all know that the peer review process is imperfect. We are happy that the procedure is as fair as it can be (most importantly that the appeal process has to be based on the submitted paper and not a revised version). Last year there were 19 appeals, out of 427 rejections. Of the 18 that we know about, 4 resulted in eventual acceptance and 14 in confirmation of the original decision to reject. In other words, you are free to appeal, but your chances of success are not high.

David Jewell

neville goodman

Surreal

Life is so surreal sometimes. The woman in the car behind was gesticulating at me. I d just parked my car and was about to go and buy a newspaper. But she looked upset about something. As I approached she wound down her window.

Why did you park so close? she said, with the emphasis heavily on the word close. She sounded as if she was going to cry. She had the steering on full lock, and it was true that she didn t have quite enough room to get out of the space if she drove forward.
I ve only got two or three inches behind me! she continued, clearly panic-stricken.

I stepped back and had a look. There was four feet of clear space between her rear bumper and the car behind. Was this a practical joke? Was I on candid camera?

You ve got four feet behind you. Would you like me to see you back? She looked even more panic-stricken. No, no! Why did you park so close?

I couldn t believe this. She was a normal looking woman of about 30. She was smartly dressed. She was not wearing glasses and did not appear to have anything wrong with her sight. Yet she clearly believed that her car was only inches away from the car behind. I wondered whether to suggest she get out of her car and take a look for herself, but after her distraught reaction to my offer of help reversing I wasn t sure what her response would be.

Worrying what might happen to the rear of my car if I left her to her own devices I decided to take the initiative and make things easier for her.

Would you like me to move a bit further forward so you can get out?

Many years ago, in Madiera, I spoke a phonetic phrase from a Portuguese phrase book to a waitress, who then convulsed with laughter and became unable to speak for some minutes. My kind offer to move evoked a similarly unexpected reaction from the woman, as if my offer were some coded expression of sexual innuendo or personal threat. With an impatient, No, no! she started revving her engine and straining at the wheel.

Logic and reason were useless. I went to my car and moved it forward a goodly distance. She still took a long time to drive out of the space.

Perhaps my total incomprehension faced with this woman s behaviour explains why I am an anaesthetist, and you are general practitioners.

Nev.W.Goodman@bris.ac.uk

our contributors

Clare Gerada is a GP in Kennington, south London. She is director of the RCGP s drug training course **c.gerada@btinternet.com**
Phil Hanniford is professor of health service research at Aberdeen University **gpr129@mailserv.abdn.ac.uk**
Iona Heath runs a luxury hostel for Scandanavians in Canonbury, London. She chairs the RCGP s Ethics Committee **pe31@dial.pipex.com**
David Jewell edits our Front Pages
Brian Keighley has just been re-elected to UK Council. He is a full-time GP and a full-time medical politician, in that order **Bkeighley@aol.com**
Roger Neighbour s champagne is about to arrive **roger.neighbour@dial.pipex.com**
Julie Sharman works in Finsbury, north London. Before becoming a GP she spent a decade or two editing a trade union journal. **julie.sharman@lineone.net**
Martin Sheehan is actually called Mark Sheehan.We got it wrong last month, so sorry about that. He philosophises in Keele. **m.p.sheehan@phil.keele.ac.uk**
Alan Shirley is yet another Sheffield GP trainer and just been appointed a course organiser. He is probably the only GP in the country who got his job via an experimental theatre group
Blair Smith is senior lecturer in general practice at Aberdeen **blairsmith@abdn.ac.uk**
Graham Smith is oral historian now based at ScHARR, University of Sheffield **Graham.Smith@clinmed.gla.ac.uk**
Andrew Thornett is Senior Lecturer in Rural Primary Care at Adelaide University Rural Clinical School University Campus in South Australia **andrew.thornett@unisa.edu.au**
Patricia Wilkie is a past chairman of the RCGP Patient Liaison Group, and is presently a lay member of the GMC **pwilkie@inqa.com**
Helena Wilton is Communications Assistant at the National Primary Care Research and Development Centre in Manchester

wonca europe 2002

Glyn Elwyn is a brand new professor, in Swansea **elwyng@cardiff.ac.uk**
Larry Green is director of the Robert Graham Center for Policy Studies in Family Practice and Primary Care, the American Academy of Family Physicians, Washington DC **lgreen@aafp.org**
David Lewis practises in Watford, Hertfordshire **dmlewis@madasafish.com**
Jane Quayle works with the VSO **www.vso.org.uk**
Graeme Walker is a final-year medical student at the University of Manchester **graemewalker@mac.com**
To inspect James Willis leading a non-PGE approved educational session in the Sound of Mull, look at:**http://www.jarwillis.fsnet.co.uk/Crew.jpg**
Tim Wilson works near Oxford. Like many academic GPs he s fond of growing vegatables on his allotment **twilson@rcgp.org.uk**

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

alan munro

Black and White

In the bay, eiders call softly to each other. Red throated divers cruise. Shags elegantly execute surface dives. On a rock, an otter glistens. Waders skitter along the sandy edge of the ocean s surge. Seals watch, curiously. At the ends of long, light days in the short northern summer, even among men, a sense of harmony grows.

On its immaculately white walls blushed by the sunset, the award winning seafood restaurant displays its owners mission statement. Our chef, a native of the village, served as sous-chef with . Behind me, in the bay, everything is itself and has its place. At least it seems so, tonight. But, in the affairs of men, the native chef shoulders his burden of *owners*. Global capitalism and its echoes of colonial exploitation are incongruous here. We retreat to the campsite and buy fish and chips from the enterprising crofter on whose land we are staying. Strictly he is no crofter, having recently bought his land, and with it, freedom. We talk with him of land reform and conservation, of governments and lairds, and miss the refinements of posh dining not at all.

Conceivably, this unexpected eruption of radicalism was to do with family events. After a long life, darkened by war, but with many days in the sun too, my mother died in our hospice a few weeks ago. For now, my own life has adopted intensely contrasting tones. The usual shades of grey are scarce.

In her last week, the hospice s doctors visited briefly, now and again. They were considerate, charming and competent, and immensely to their credit, conveyed an impression of being discreetly available in the background, if required. Played with delicate restraint, their role was to support the nurses. As a chef is the essence of an eatery, so the nurses are the heart and muscle of a hospice.

We soon knew the nurses well. Each was independent, kind, caring and skilful. Our anxieties were managed and our demands satisfied or even anticipated, in spite of five of us being doctors in our other lives, surely an appallingly intimidating proposition. Each nurse brought to the job his or her unique resources of personality, unsparingly committed to maintaining the integrity of the ragged little family group around its dying mother.

Curiously, we reward doctors generously, nurses rather less so.

In the practice where I work, the computer person s skills are indispensable. She facilitates the work of the doctors, whose work in turn is the main business of the enterprise. She also answers the phone and deals with patients at the desk as required, mopping up without fuss the million and one small jobs which daily keep the show on the road. She has the unenviable task of reducing to computer code the ramblings of her indisciplined medical colleagues. The originality of her invective when herding physicianly cats is legendary. She too is rewarded frugally, very frugally compared to a partner, a curiosity with which we both have lived strangely amicably, for long enough.

Any scintilla of sense, far less justice, in these differentials eludes me utterly. Marx thought that history is an account of the maintenance of their privileges by the few, by fooling the many into believing that they are well off, or well enough at least to postpone revolt until tomorrow. To me, his analysis has always felt right.

I tend to excuse my usual lack of revolutionary fervour in feeble contemplation of the difficulty of achieving equity, and an occasional wringing of hands. In contrast, my mother had a more press on approach to ideological perplexity. My most vivid memory of her, for the present, is the interview she conducted, to determine his suitability, with a minister of the Kirk whom we thought might conduct her funeral service.

should like to make just one stipulation. You may not under any circumstances mention God.

His face betrayed not a flicker of surprise, heart sink or panic. In due course his service was as stipulated, and for us he achieved a fine blend of humour, sadness, thoughtfulness, solemnity, resignation, and hope. Indeed, were his talent to become widely known he might have little time left for Christians.

If God can be challenged, why not inequality? Its persistence is after all nothing more than a reflection of our addiction, shared with chimpanzees, to status games. The Dutch, French, Germans, Scandinavians and Japanese do manage in this respect to be less like apes than we do.