# The Back Pages

## viewpoint

**Are GP leaders scared of sex?**

EVERYBODY is entitled to reproductive and sexual health care, so why is general practice taking such a back seat? First, the RCGP withdrew from the foundation of the Faculty of Family Planning and Reproductive Health Care (FFPRHC) in 1993. Now the new GP Contract again classes contraception as an additional service.[1] This is a missed opportunity. Even worse, it will have to be whole practices, not individual principals, who 'opt out'. Who is kidding who? What sort of ethos is this?

Most practices will hopefully not opt out *if* the price is right, but there will be some which, for various reasons, choose not to provide this most essential service. Who will ensure that disenfranchised patients will be able to receive adequate and easily accessible reproductive health advice?

Surely reproductive health care should be a core component of general practice. Not only should female contraception continue to be freely available but condoms should also be freely available from all practices. Don't men matter? Managers totting up our prescribing costs need to know that contraceptives/barriers represent remarkable value for money. A condom may cost 65p to buy (much less wholesale), but HIV can cost £12 000 per year to treat. What is the cost to society of an unplanned child to a reluctant, poorly-bonded mother, probably already struggling with other children in poverty? No wonder mental ill health is rife!

Even our MRCGP exam does not demand such knowledge; a registrar may join a practice with no particular interest or expertise in this all-important area.[2] From my own observations in teaching sessions with GP registrars, it is the men who seem the more likely to lack experience and confidence in this area: we need to improve on this. If professionals do not feel confident and informed in talking about things sexual, then how on earth can we hope that the British public will be able to cease viewing sex as taboo, rather than a normal part of life?

Over 99% of the population is registered with a GP practice; we perform nearly all the cervical smears and provide approximately 65% of contraceptive care to women. Primary care professionals have countless opportunities to offer help; for instance, contraceptive advice during pregnancy, baby clinics, victims of domestic violence, injecting drug abusers, acned teenagers, impotent diabetics or gay young men. For a highly developed country with an essentially free and socialised health care system our statistics could be better — the worst in Europe for teenage pregnancies, chlamydia rates still rising, and an estimated 50% of conceptions overall being unplanned, with at least 25% of women undergoing a termination of pregnancy in their lifetime.[3]

The Diploma in Family Planning (DFFP) is viewed as a desirable qualification for GPs providing contraceptive care.[4] The Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists is to be admired for its innovative work in establishing a strong educational programme. However, there is no requirement for a single GP to be on its Council.[5] The diplomates are represented by a single place on Council, but this year, as usual, the one nominee was a gynaecology specialist registrar. So how can general practice be adequately promoted and represented within the FFP, which aims to promote a high quality of practice to all providers of sexual health services?

How can informed decisions be made in representations with the government when planning future sexual health services? General practice is only represented by one RCGP voice in the English Sexual Health Strategy.[6] Yet this strategy (where emphasis seems to be only on infection) proposes a broader role for those in primary care.

North of the Border we have, as yet, no sexual health strategy, with the exception of the Scottish Programme for Clinical Effectiveness in Reproductive Health. A recent evaluation commended SPCERH for work with a strong primary care focus, yet the multidisciplinary panel did not include a single GP![7]

Come on, RCGP — we owe it to our patients to tell the world how much we are involved, so we can work and train better together to improve our patients' lot.

**Penny Watson**


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4. Royal College of General Practitioners. PEP CD ROM 2000. Chapter on family planning.
5. www.ffprhc.org.uk section on council membership (accessed 28 July .2002.)
6. www.doh.gov.uk/nshs/members (accessed 28 July 2002.)
7. SPCERH. Aberdeen Maternity Hospital, Newsletter number 10. May 2002.


**"Like general practice, β-adrenergic blocking agents have a reputation for causing depression, fatigue and sexual dysfunction: according to this review, largely undeserved (by β-blockers, anyway)..."**

**Theophrastus Bombastus inspects the literature, page 779**

**"There is a great story of McEnroe having a tantrum in one of their games at 5-5 in the fifth set. Borg beckons him to the net, puts his arms round him and quietly exhorts him to 'Relax, after all it's a great match'. One can only be shocked that McEnroe did not floor him, but for once the respect for his combatant overcame him."**

**David Tovey dribbling over John McEnroe, Digest, page 786**

## contents

## The End of the Affair — Public Health Medicine 1974–2002

*'Let us not speak for the love we bear one another,*
*Let us hold hands and look,*
*She, such a very ordinary little woman,*
*He, such a thumping crook.*
*But both, for a moment —a little lower than the angels*
*In the teashop's inglenook'*

'In a Bath teashop', John Betjeman

THIS poignant, doomed cameo of middle-aged love is redolent of the love affair between medicine and public health. In 1974, with a re-organisation, a new Faculty of Community Medicine, the demise of the Medical Officer of Health and the integration of Public Health into the NHS with consultant status, the future was rosy.

The Faculty grew in numbers; an attractive career path beckoned; able graduates entered the specialty. In particular, many women saw a career that enabled the roles of wife and mother and doctor to be juggled more easily. Today, over 50% of Consultants in Public Health medicine are women.

It was good while it lasted. There was the chance to work across the width of medicine; there was the opportunity to have real influence on key decisions. A numerate doctor with some knowledge of social sciences was a phenomenon and a benefit. Of course there were alarums and excursions, re-organisations, political chicanery; but like any marriage we muddled through.

The first warning was the purchaser–provider split. Public health doctors retreated into Health Authorities, into larger departments and further from the clinical action. They no longer worked on a daily basis with clinical consultants, no longer did they act as peripatetic personnel officers for disgruntled colleagues or try to sort out the competing demands for beds, theatre space, expensive drugs, and junior doctors' hours. With the rise of GP fundholding they no longer acted as GP philosopher, advisor, and friend. They no longer jostled in the street of medicine.

So public health grew away from medicine and now has been disowned by medicine. Public health has trained non-medical specialists to do the new job — the numerical, analytical, epidemiological, and planning tasks. Appropriately, the work has passed to the specialists, who may do it quite as well but at a lower cost. The medical premium is no longer worth the price tag. The Faculty of Public Health Medicine is now the Faculty of Public Health. By 2022 most members will not be medically qualified and there will be a non-medical president.

Can public health medicine re-emerge in the PCT? Primary care is not a life raft for a disinherited cohort of public health doctors; it is changing rapidly from a cottage industry to a Health Maintenance Organisation. The challenge is to make the change without losing the strengths of the practice, the partnership, and the personal list.

The new primary care must take account of the organised use of a range of staff skills and a rethinking of the nurse–doctor interface. Primary care will provide increasingly wide and effective treatment and management options as acute hospitals retreat into high cost and high-tech work. Most treatment and care will require community services, hospitals at home, intermediate care; all are the province of primary care.

Information technology, information brokering, and rapid access to hospital records, hospital colleagues and patients will be the norm. As the telephone was to the 20th century, so the video consultation, e-mail diagnosis, and distance-based management will be to the 21st.

This surely must be the new challenge for doctors who relish the task of public health, for here is a new and demanding opportunity to 'make the health of the people the highest good'. The clinician/epidemiologist is reborn in the PCT.

In future, the specialty will need to train quite small numbers of doctors (perhaps 200 for the UK?) in public health. A MPH qualification plus an MD following a postgraduate clinical qualification may be most appropriate. The Faculty and the Faculty examinations will be concerned with the training and development of public health specialists.

*'The dogs bark and the caravan moves on.'*

*The Golden Journey to Samarkand*, James Elroy Flecker

**Peter Sim**

## RCGP 'Virtual Genetics' Group meeting: 'The Use of the Family History in Primary Care'

THERE were two main foci to discussions in the meeting. First, the group considered the use of the family history in the context of the management of specific diseases. What constitutes 'good practice' with respect to seeking family history information is not yet clear. No-one supported the use of the family history as a general screening tool at this time, as there is insufficient evidence for effective interventions to offer to all those who screen positive. However, GPs should be proactive in asking about the family history if it is felt that it will alter the management of, or give a health advantage to, the presenting patient; for example, if there is a family history of cardiovascular disease (especially in Afro-Caribbeans and Asians) or colorectal cancer.

Secondly, the Group considered the 'added value' of the family history in primary care. Members felt that knowledge about aspects of the family history, including social and cultural information, is part of the comprehensive care offered over time, by general practitioners. If the full potential of the family history is to be realised, then the process of recording information needs to be standardised and realistic in the context of general practice. Eventually, the family history will need to become part of the electronic patient record. Information systems will be needed to help GPs analyse the pedigree. It takes about 20 to 30 minutes to obtain an accurate family history and convey key conclusions using guidelines and decision support systems. Thus, there are issues around the feasibility, as well as the reliability and accuracy of the use of the family history in general practice.

Several important questions were raised:

— How should the family history be used in general practice?
— How much information should be obtained?
— How accurate is the information likely to be?
— How should IT tools be used to gather information, with the aim of eventually incorporating it into the electronic health record?

Three areas were thought to be of interest to both primary care and public health in the field of primary care genetics:

1. The circumstances when it would be appropriate to use the family history as a means of identifying genetic and reproductive risk.
2. Clinical governance and the evidence-based use of the family history within a protocol for the management of a specific disease; for example, colorectal cancer.
3. Quality standards regarding education and training of health professionals in genetics.

**Rhydian Hapgood**
**Michael Modell**

*Full report at: http://www.rcgp.org.uk/rcgp/clinspec/genetics_group/geneticgr.asp*

# flora medica

**From the journals, July 2002...**

***N Engl J Med* Vol 347**
**5** For centuries, the Italians have sung of the **inflamed heart**; now they have done this study using a marker of local inflammation (leucocyte myeloperoxidase) showing that the **whole coronary tree is inflamed in unstable angina**. *Nel cor piu mi sento!*
**81** Over the last couple of decades, some operations have gone out (T&As, D&Cs) and others have come in — **arthroscopy, debridement and washout of the arthritic knee** being an example. This study (with control sham surgery) shows that it makes no difference whether the arthroscope goes in or stays out.
**161** The easiest way to tell whether the heart is struggling is to measure **β-natriuretic peptide**: there is now a bedside blood test which can tell A&E doctors whether **acute breathlessness** is cardiac or not.
**262** While it's very gratifying to find a high ESR and transform the life of a patient with **polymyalgia rheumatica** using steroids, it's not long before you worry about the weight gain, moon face and osteoporosis risk, all incurred because of a single non-specific inflammatory marker. **Ultrasound of the shoulders** showing **bilateral bursitis** is an important new way of confirming the diagnosis, as this useful review points out.

***Lancet* Vol 360**
**6** The Oxford **Heart Protection Study** provides robust evidence that we should give a good dose of **statin to all at high coronary risk**, irrespective of cholesterol level.
**109** But how do you fancy giving **warfarin as well as aspirin** indefinitely to everyone who has had a **coronary event**? ASPECT-2 suggests we should.
**187 Breastfeeding protects against breast cancer** in a seemingly dose-related manner.
**252** In a splendid essay, Graham Watt revisits the **Inverse Care Law**. *Plus ça change …*
**278** Surgeons in a general hospital come up with a simple **scoring system** based on history alone to assess the **risk of colorectal cancer**. See if you think it passes muster.

***JAMA* Vol 288**
**49** In this paper on HERS-II, *JAMA* began the process of disillusionment with the **protective effects of combined HRT**. This study of older women with coronary disease found none, and most other outcomes were worse too (page 57).
**321** And after HEARSE-II came the complete funeral service of HRT optimism in the report of the **Women's Health Initiative** study.
**324** The **oestrogen-only** arm of that trial continues, but we have evidence from another that this increases **ovarian cancer**.
**351** Like general practice, **β-adrenergic blocking agents** have a reputation for causing depression, fatigue and sexual dysfunction: according to this review, largely undeserved (by β-blockers, anyway).
**455** Now that we'll be giving **statins** to lots more people, it's worth making sure that they will actually take them. Oldies in the USA and Canada (page 462) often don't bother.

**Other Journals**
Looking over the water, 'family medicine' in the USA is used as a comparator in a big study of **physician satisfaction** (*Arch Intern Med* 2002; **162:** 1577-1584). It's not what you might expect: ENT is the least satisfying career, while geriatric medicine is the most.

In the American Emergency Room, glue or suture for **scalp wounds**? Select an opposing pair of hairs in your forceps, twist them together, and drip a drop of glue on. Repeat as many times as necessary (usually 4 or 5) and the results will surpass suturing (*Ann Emerg Med* 2000; **40:** 19).

Donald Berwick has a real instinct for where patient care might be improved: here (*Ann Intern Med* 2000; **137:** 117-122) he turns up trying to improve the quality of **end-of-life care** using a PDSA cycle: Plan, Do, Study and Act. In a US nursing home, moreover.

Meanwhile the Aussies have looked at what might need doing to relieve **pain in nursing home residents** (*Med J Aus* 2002; **177**). Listening to the residents is always a good start: 28% complained of pain, and there was little correlation between this and reported pain in the nursing notes. I think I prefer ILSA: identify (a problem), listen, study and act.

Meanwhile, those off to the Dolomites for a late holiday should read 'Geographical information systems and bootstrap aggregation (bagging) of tree-based classifiers for **Lyme disease risk prediction** in Trentino, Italian Alps' (*J Med Entomol*).

**Plant of the Month: *Aconitum stapfianum***
Most of your shrubs will have lost their flowers by now, but you can confuse the unwary by planting this aconite right under them. All of a sudden their leaves will host monkshood flowers of dark blue, from the climbing stems of this poisonous perennial.

*Being an interactive sort of chap, Theophrastus welcomes suggestions for his monthly review. Even he can't read everything! What gems deserve a wider readership? Suggestions from August (not august) journals to* ***journal@rcgp.org.uk*** *(marked* ***ftao TB****). Tiny prizes available for published nominees...*

**Transcripts of interviews can be downloaded at the ScHARR website:**

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


**References**

1. The project was funded by the Wellcome Trust's History of Medicine programme.
2. See the *Nursing Times*, Saturday 3 July, 1948, Vol xliv, No.27, page 471: 'Nurses are fortunate in being a most essential part of the service. Some nurses have been appointed to help in the control and management of it. The majority will, in many people's minds, *be* the service. More nurses will be visiting the homes of the people as health visitors, domestic nurses and midwives. More people will meet the nurse at the clinics, health centres and hospital outpatient departments, and they will judge the service by the personal care and consideration they receive.' See also 'Towards a Real Health Service' in the *Nursing Times*, Saturday 3 July, 1948, Vol xliv, No.27, page 475: 'The distribution of individual duties is less important than making sure there is true teamwork. For the first time in our history, the health visitor, the district nurse and the midwife will all be employed, directly or indirectly, by the same employer, the county or county borough council, and will be under the control of the same chief officer.'
3. Jeffreys M. General practitioners and the other caring professions. In: Loudon I, Horder J, Webster C (eds). *General Practice under the National Health Service 1948-1997*. London: Clarendon Press, 1998: 128-164.
4. Cartwright A, Anderson R. *General Practice Revisited*. London: Tavistock Press, 1981: 41-46.
5. GPP 03. Compare this statement with Damian S's (GPP 19) presented in the second article in this series, (Smith G. An oral history of everyday general practice 2: Why do GPs become GPs? *Br J Gen Pract* 2002; **52:** 604-605.
6. GPP 07.
7. GPP 06.
8. GPP 18.
9. GPP 09.
10. GPP 27.
11. GPP 15.
12. GPP 21.
13. GPP 28.
14. GPP 09.
15. GPP 04.
16. GPP 05.




**Introduction**

RETIRED doctors are constantly surprised when they see the increasing numbers of personnel that are filling premises to bursting point; the employees recalled by the oldest doctors in the Paisley project belong to a bygone age. At least one of the town's practitioners boasted a chauffeur, while most engaged housekeeper-receptionists.[1]

The optimism generated by the idea of the health care team is not new. In 1948, nurses expressed enthusiasm for the imminent National Health Service and the opportunities for co-operative working that it promised,[2] whereas doctors initially were less enamoured by the prospect. Today, many are knowledgeable and supportive of their staff and attached personnel. Nevertheless, there are distinct areas of tension, revealing an ongoing process of redefining professional roles.[3] While some of the changes inherent in the development of the team can be seen as advantageous, others seem to represent a threat to the position that doctors have traditionally held in the delivery of primary care. The testimonies of GPs reveal numerous issues that can be seen both to underpin and to undermine the primary health care team. These issues include issues of power, status and the skill mix within the practice, as well as wider issues of medical responsibility and professional autonomy. All of these contribute to a reappraisal of the doctor's own role in an effort to maintain the unique value of being a GP.

Perhaps the most challenging realisation that doctors have encountered in the development of the team is the utility of the nurse. The nurse's expanded role goes beyond taking on medical tasks to include exercising what is regarded within nursing as one of the nurse's more established skills; that is, social assessment, providing a more holistic knowledge of the patient and the community. While nurses seem to be particularly confident in this area, patient care in the community has been seen at different times as an area contested by practitioners and nurses.

Among the attached personnel, it is the changing relationship with district nursing and the subsequent growth in the numbers of practice nurses that best encapsulates the fluidity of professional boundaries in general practice. The well documented decline in the doctor's home visits[4] marked a watershed in the relationship between nurses and doctors. In the early years of the NHS, the number of house calls requested of doctors increased, placing doctors under a great deal of pressure of time. As district nurses became attached to practices in the 1960s, improved communication and partnership between GPs and nurses saw a decrease in doctors' house calls as nurses were able to take on some of this work. The oral evidence suggests that, prior to this decrease, doctors were much more ambivalent about the role of district nurses. After the reduction in home visits, doctors were much more likely to view the nurses in a more positive way, although the decline itself encouraged an expansion in the remit of district nursing.

The legacy of this unspoken historical settlement is the prevailing ambivalence in terms of the nurse–GP relationship. Some practitioners appreciate that the district nurse saves the doctor time, while others are not entirely comfortable with the extension of the district nurse's role. That the notion of autonomy is constantly being negotiated between individual members of the professions also reflects the tension of the nurse–doctor relationship within contemporary general practice. While the doctor needs to utilise the nurse's skill without the added work of supervision, the boundaries of autonomy are blurred, with no clear consensus among GPs of what the nursing role does and should involve.

The changing role of all primary health care team members can be seen in the expansion of the nursing role and in the creation of new posts (including specialisation of administrative posts). There are new opportunities available for the development of traditional practice jobs; for example, receptionists becoming practice managers. Not only have the number of posts in practice increased, the responsibilities attached to these posts are constantly being redefined.

For some of the Paisley doctors a growing practice team is a source of status — an indication that the practice is making progress. Others are less sure and reservations were expressed, including the difficulties of managing large numbers of employees. Concerns were also aired about whether the quality of patient care was becoming compromised, with some of the doctors spending increasing amounts of time on managing the growing bureaucracy of practice. Many of the working GPs were to varying degrees unsatisfied with the way their primary care teams had evolved and hinted at their lack of control over this evolution.

While the strategic interventions of receptionists and nurses have streamlined the service, and specialist tasks that were hitherto the province of the GP have been devolved to other staff, the doctor has remained essentially passive. Perhaps these developments have served to reinforce the generalist nature of the GP and indirectly raise the profile of the medical skill of diagnosis, which remains firmly in the GP's domain. The success of the health care team begs the question of the relative value of medical diagnosis, which seems to be the only secure place for the GP in the present situation.

**The oral evidence**

GPP3 recalls his practice establishing an appointment system rather earlier than other practices in the town: *'In 1953 we started* [an] *appointment system … and the receptionists were completely looked after. One or two occasions you got a nasty person in and were told to leave the list. But our receptionists were first class … They are the first people to see the patient, they've got to welcome them to the place, treasure them. If the matter seems urgent they'll push them through. If they look a bit sad and weary give them a cup of tea …'*[5]

For most practices the Family Doctor Charter marked a change in the duties and status of reception staff.

**Robert E:** *'Prior to 1966 we had a kind of housekeeper-receptionist. We had a flat attached to the old surgery and we had a family who lived in it. The wife of the family kept the close* [the tenement's common lobby] *clean for us and she answered the phone for us during the day. When we formed the group practice and moved to the premises in Neilson Road we no longer needed a receptionist-housekeeper of that kind. She got a council house and we continued to employ her as a receptionist. She was full-time and we had two part-time ones then one of the part-timers became full time that was sufficient for many years. I don't know how they get on with things nowadays, but they seem to have a staff of about a dozen in the place now.'*[6]

Different doctors took a variety of approaches to appointments and reception staff.

**David R:** *'I always had three receptionists and we were open six days a week and we always ran open surgeries. Because one of things that pissed me off most about the previous practice was the way in which they just came down on the patients every time … I thought it was a dreadful appointments system and it utterly discriminated against the poor. You know, they* [patients] *didn't have the same options, because they had to think about the bus connections all the time because they were in the peripheral schemes. And secondly, they didn't tend to have the phone so all the receptionist had to do was keep them on the phone till their money ran out* [laughs]. *'*[7]

Since 1990, practice administration has not only grown, but has also included new groups of staff.

**Linda F:** *'So it's five receptionists and a practice manager… It's been a gradual thing over the years. I think the first increase was 1990… There's more forms to be filled in, there's more things that need to be discussed, there's more bits and pieces to be planning.'*[8]

**David D:** *'When I came here* [in 1988] *… the practice had absolutely no management structure … we had a book-keeper but the principal seemed to do everything in terms of actually dealing with the genuine business side of things … We did have a manager, probably quite late in the game in relative terms compared to other practices … and then we went through a number of managers with a series of disasters, because we were totally unrealistic about our expectations of the manager. These people came in and they would all have significant strengths in one area or another but be completely disastrous in one area or another. Eventually we got so disillusioned with the idea of having practice managers that we decided to abandon that completely. … We now have a reception manager and a practice administrator.'*[9]

The employment of new staff has added considerably to the pressure on space within practice premises.

**Gerard D:** *'So when we want to bum* [boast] *we add on two extra rooms. We talk about 'the office', the practice manager's 'office' and … we talk about 'the computer room'. I mean there's no door to it or anything. I mean it's a corner in the corridor.'*[10]

Establishing the primary care team has been slow and there have been difficulties, including communication between GPs and nursing services that reflect a wider tension arising from sharing responsibility for patients.

**Q:** *Has the role of the district nurse changed in your time in practice?*

**Donald W:** *'You mean did district nurses seem to me in 1964 to be the enemy? Were health visitors the enemy? By that I mean that your district nurse would go out and see somebody in the morning and she'd put in a call in the afternoon, and the same with the health visitor. …So you then found yourself picking up these things, which had been probably known for a while but have now come in as a so-called 'emergency visit'. And that didn't go down well… Well this was work that they were introducing at a time when you'd already done about 14 calls that day, and a long surgery, and you knew there was another long surgery coming up, and you were in the process of trying to digest a meal, and they're on the phone. So, yeah they were looked upon as the enemy* [laughs] *in that sense.*

*'District nurses are very much part of the team* [now] *and if there are problems you have a chat with them and when there are long-term problems with people they're more in charge of the situation really than you are. I mean the health visitor and district nurses I see every day and have a chat with and if there are problems we decide how to app-roach them and how we should go about it.'*[11]

John H recalls in the early 1980s discussing caring for patients with Parkinson's Disease with his trainer: *'Now I had swotted up on Parkinson's disease and seen lots of folk in hospital and I thought I knew everything about it. … And it was very obvious that I didn't know about dealing with people at home with Parkinson's disease. "How do you manage this?" And I said, "You give this drug, that drug and the next drug". And he said, "Well no, that's not what we really mean by managing it. You involve your district nurses, you get the OT out… and you organise care". … And you learn more about teamwork in general practice and they had regular meetings with the whole practice team; the social worker was involved as well. There was a much better relationship between the social work input there.'*[12]

Practices recruit and retain staff in a variety of ways.

**Fiona T:** *'The two girls who are currently practice nurses are the only practice nurses we've ever had. And they both came from our district nursing staff. We pinch them. Ehem, our health visiting staff, has evolved over the years … but we haven't had a great deal of turnover of nursing staff. … So I hope that reflects that they, feel as if they're a valuable part of the team.'*[13]

Some of the GPs spoke of having to acquire understanding with individual non-GP colleagues.

***David D:*** *'I think partly it's initiative and partly it's fulfilling a role that complements what we're doing and obviously you've got to complement what they're doing as well… There's one of my health visitors that I know when to involve her and she knows when to involve me … it's a negotiated order, it's a negotiated position over time.'*[14]

There is a sense among some of the younger GPs of continuing tensions in the primary health care team.

**Graham D:** *'Nurses are very good at working to protocol … but nursing as a whole is under-utilised. I think there's a danger that if we over-utilise them there'll be less of a job for ourselves being that there is a lot of things that they can do and do very well.'*[15]

This feeling that the nurses are doing too much was reiterated by another GP with reference to the concerns of dermatologists.

**Brian R:** *'The dermatology system is being redesigned and the dermatologists are very nervous about the nurses looking after leg ulcers and having access, if the nurse isn't happy, to refer directly to the clinic. They would rather that the nurse asked the GP for an opinion and the GP referred to the clinic ... The GP's job is changing all the time. What we've got to do is, or I've got to do as a GP is, I've got to make sure that I'm doing something which is something I can do. For instance, only I can do.'*[16]

**Rona Ferguson**
**Graham Smith**

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I argued in my previous article in this series (August *BJGP*) that medical practice that is good both for doctors and patients must take account of the personal qualities of the doctor, and not merely focus on abstract questions of rights, duties or maximising good. If this is true then we face two tasks:

- defining the personal qualities or virtues required to flourish as a doctor
- establishing how to cultivate those qualities and create structures that support them.

The first, logically, has to precede the second and must be our starting point.

Philosophy is traditionally a solitary activity — you will find few collaborative books or papers on the philosophy shelf — in contrast with medicine, where multi-author publications are the rule rather than the exception. There are, however, powerful reasons to believe that the virtues of the general practitioner are better defined by a group of practitioners rather than by an individual philosopher or philosophically inclined doctor.

Firstly, as with any aspect of medical practice, there will be a common core of qualities essential for any doctor fulfilling a particular role, such as that of the general practitioner. This common core is probably best defined from the shared experience of a group of such practitioners, using the methods of qualitative research.

Secondly, all doctors are individuals, and there will almost certainly be alternative ways in which doctors can be virtuous. The reflections of one practitioner may be idiosyncratic (and, if that practitioner is interested in philosophy, are highly likely to be so!) Pooling the experiences of a number of practitioners will help us define these variations.

As I mentioned in my previous article, issues in medicine typically involve both facts (claims about the link between two states of affairs and how we move from one to another, i.e. they concern 'means') and values (claims about the desirability of different states of affairs, i.e. they concern 'ends'). Facts can be established by quantitive or qualitative research, while values are appropriately explored by philosophical argument.

The points above could be made about any question of fact in medical practice. Virtues, however, include both questions of fact and of value. Flourishing is an end, so what counts as flourishing — living the good life as a doctor — is a question of value. The qualities one needs to achieve such a state (the 'means') is a question of fact. Many virtue ethicists suggest that the virtues are both means and end — they are both the route to the good life and part of it in their own right.

We therefore have to consider the appropriate way to explore questions of value in our definition of the virtues. This is the third reason for involving a range of practitioners in defining the virtues of medical practice. As a profession, the values of medicine cannot be determined by an individual, but only by its practitioners working together in collaboration with wider interests in society.

For all these reasons, therefore, I decided that a collaborative approach to defining the virtues was needed. There is no established methodology for collaborative definition of the virtues. There are, however, well established techniques in qualitative research and in education for enabling a group of people to work together to generate a collective view on a topic. The first step, therefore, was to test out various methods with an interested group.

I decided to start with a group consisting solely of general practitioners. Although ultimately it will be essential to involve other types of doctor, other health professions, and representatives of patient and political interests in this process, it seemed simplest in addressing what was already complicated enough to start with a homogeneous group from a practice that I knew well. In fact, as a result of a misunderstanding, a philosopher was included in the 20 or so who assembled for a 'research seminar' in April this year. One of the first lessons was what a valuable resource he was, and I was sorry that I had not included a few more whom I knew to be interested.

The obvious place to look for methods was qualitative research. Although it has become something of a cliché, the focus group has become so popular because it is a very powerful method of generating data, and so ignoring it would have been perverse. We had two focus groups in parallel: one on beneficence and one on courage. They generated a tremendous quantity of ideas about what it meant to display these virtues in general practice, supporting the value of the small group as a way of generating knowledge.

Balint has had a tremendous impact on general practice, and I have already suggested that Balint work may be seen as one way to cultivate the virtues needed for general practice.[1] It seemed logical, therefore, to include a Balint group in the research day (or two Balint groups, in fact,

since we were too many for one group). Along the lines of an Ignatian spiritual exercise,[2] I asked the group first to discuss the case as in a normal Balint group, with the support of a very experienced leader, and then to spend some time reflecting on the experience and trying to identify the virtues that were demonstrated (or absent) in the case discussed.

While the cases discussed in the groups were fascinating (and the case opposite is one that was discussed there), the attempt to 'debrief' and look at the virtues of the doctor was almost entirely fruitless. We were anxious beforehand that, without the trust that builds up over a period of time in a closed group, it might be impossible to address such sensitive issues, but this did not seem to be the difficulty. Rather, it seemed that Balint work and philosophical analysis are different ways of thinking, and participants found it impossible to switch so quickly from one mode of discourse to another.

Nussbaum and Sen[3] have suggested that a useful way of looking at the virtues is that they are the qualities needed to overcome the challenges of life. This seems a credible and simple notion, and so I decided to take that as my starting point for another approach. Medicine is above all about stories,[4] and virtue ethics may perhaps best be explored as part of narrative medicine. In the first exercise of the day, therefore, I asked participants to think of stories in which the doctor faced particular challenges, and summarise them in a few sentences. I asked them to identify the challenge posed in the story and to indicate qualities they thought were needed to overcome the challenge. The stories could be about success or failure; where the challenge was overcome or where the challenge overcame the doctor.

Although I allowed insufficient time for the participants to write down their stories, and added to the time pressure by asking them to organise the qualities they came up with into groups, a tremendous number of fascinating ideas were produced in a very short time.

I am in the process of analysing this data and unpacking its implications. Everyone enjoyed the day and was keen to do more. When I ran a workshop at the WONCA conference in June this year, in which I gave groups the last task described above (but with a lot more time to discuss the cases), a further fascinating point emerged. Unlike my academically inclined research seminar participants, people come to conferences expecting to learn and grow. In the feedback session it became clear that they experienced it as a valuable piece of self development — perhaps in itself a means of cultivating the virtues, at least that of practical wisdom.

There is much more to do, and the second task — developing an understanding of how to cultivate and measure the virtues as part of medical education and discovering how we organise our practice to support doctors in exercising them — has hardly begun. A new methodology for the empirical definition of the virtues in medicine is, however, beginning to emerge. Readers who would like to become part of this process should contact me by e-mail to join the virtual and face-to-face groups that will be continuing to explore this fascinating area.

**Peter Toon**

## Example

*A young doctor previously unknown to you is discharged from hospital with her first baby with Down's syndrome — her husband, a physiologist, is clearly distraught and cannot accept this event.*

*You are asked to advise — you judge that this is going to destroy this parent's relationship and strongly offer the possibility of arranging adoption. It is accepted. (They then have three brilliant sons and a successful professional career.)*

The author defined the challenge as *"Have you the right to offer such a solution?"* Traditionally the doctor's role is to cure or relieve illness, help patients avoid it, and to help them understand and cope with their illnesses. Providing advice like this lies outside this role, and some would consider it unprofessional to take a strong line (as opposed to helping people define the options non-directively).

The quality which the author suggested this case demonstrated was *"Intuition, judgement of the harm that might ensue if such advice was withheld".*

This gives insight into the nature of practical wisdom in general practice. An evidence base of general facts may help this; for example, data on marital breakdown in families with mentally handicapped children. But applying this general knowledge requires an imaginative capacity to predict accurately the likely consequences of different courses of action. This requires both empathy — the ability to imagine what it will be like for those particular people facing that situation, from the inside — and impartial insight into their likely reactions. It also involves a view of a good life for each of the parties concerned — the couple and their handicapped child — and also possible future children in the family. Traditional medical ethics would be inclined to see this as paternalistic and inappropriate for a doctor.

To act in this way clearly demonstrates courage — but if they had followed the advice and it had gone horribly wrong, would this have been foolhardiness? Most doctors can recount stories about when traditional role boundaries had a good outcome. I recall a case of a mother who persistently missed routine appointments for her child's asthma, and then called in an emergency when he was seriously ill. After several months of patient explaining and attempting to understand her behaviour, one day when I was called out and he was very ill I lost my temper and told her she was being a terrible mother, neglecting her child! After this outburst of honest anger her behaviour changed completely and her care, his asthma and our relationship improved enormously.

Such successes in difficult situations are very satisfying to the doctor concerned. The satisfaction of overcoming the difficulty and the awareness of having been courageous, perceptive (and right!) are part of

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ALTHOUGH there is an argument that the limits to health care demand are within the capacity of a properly resourced NHS,[1] it is generally agreed that not all citizens can receive the health care from which they could benefit.[2] Difficult choices about who gets what and who goes without are inevitable.

The recent announcement on how the treatment of multiple sclerosis with β-interferon is to be managed has brought the rationing debate into sharp focus. Having being rejected by NICE on the grounds of limited cost effectiveness, the drug is to be launched in a ten-year naturalistic trial overseen by an already stretched neurology service with a sliding price scale based on results. Alan Milburn has stated that the drug 'has a unique history which demands a unique solution'.[3] Is this decision a one-off special case or does it offer more profound insights into the emerging rationing debate?

**The background to rationing — from implicit to explicit decision-making**

Historically, clinicians have been left to 'jiggle a quart of services from a pint pot of resources',[4] making implicit rationing decisions by a mixture of deterrent, denial, delay, deflection, and dilution.[5] Some commentators have argued that this process has worked well. Confrontation with the harsh reality of rationing can lead to discomfort for both decision makers and patients.[6] However, over the past decade the call to make rationing more explicit has been driven by a number of factors:

— a more educated and informed consumer;
— decisions may be influenced by professional interests;
— resources may not be used effectively or efficiently; and
— availability of interventions varies across the country, leading to inequity.

Explicit rationing is characterised by the use of rational decision-making frameworks. Here, the decision maker selects from a group of alternative courses of action that can be identified in terms of their costs and consequences, assuming clear criteria for the evaluation of these competing claims.

**The background to NICE**

To avoid the problems of implicit decision making and, in particular, the development of 'postcode' rationing, the National Institute for Clinical Excellence has been established in England to make recommendations at a national level.[7] Its deliberations are required to take into account:

— the degree of clinical need of people with a condition (a contested concept, but in general what an agent sanctioned by society thinks will benefit the patient). NICE also takes note of wants (what patients or their representatives think will benefit them); and
— the balance of benefits and costs (is the increment in cost of an intervention commensurate with its increment in benefit?).

It is not required to take into account:

— public opinion (although a survey found that 84% of responders thought that β-interferon should be funded,[8] research on the representiveness and rationality of public consultation has shown serious problems in discovering what most people actually believe.[9] Given the same evidence, members of the public at different times and different places make different decisions[10]); and
— affordability or prioritisation guidance. Cost implications of recommendations are of no concern even though health care budgets may be fixed.

**The background to β-interferon**

Beta interferon is the only licensed treatment for which there is evidence of benefit in the treatment of multiple sclerosis[11] and evidence-based guidelines for its use have been issued by an international expert panel of neurologists.[12] Its main impact is on relapsing–remitting disease where it reduces the frequency of relapse by 30%, equivalent to one relapse avoided every 2.5 years. Formal clinical trials have demonstrated this improvement for two years and observational studies for four years. The effects on disability in the longer term are unknown.

In 1995 the NHS Executive issued guidelines on the use of β-interferon in multiple sclerosis, based on clinical effectiveness alone,[13] and suggested that clinical responsibility for prescribing should remain with hospital specialists. Health authorities took different positions, resulting in 'postcode' rationing.

**NICE's β-interferon decision**

In January 2002, NICE recommended that, on the balance of clinical and cost effectiveness, β-interferon could not be recommended.[14] The treatment was to stumble at the economic hurdle.

An economic evaluation is a comparison of alternative courses of action in terms of both their costs and health benefits. Its aim is to facilitate the choices of decision makers in order to utilise limited health care resources

efficiently; i.e. to confer the least sacrifice on others. Although there remain a number of methodological concerns,[15] the measurement of benefit favoured by NICE is the quality-adjusted life year (QALY).[16] This is a unitary outcome measure that encompasses both quality and quantity of life and has the advantage of being able to compare competing interventions that have different clinical outcomes.

However, because of the necessity to model long-term economic implications on the basis of short-term studies and the inevitable susceptibility to publication bias in favour of pharmaceutical interests,[17] initial estimates of the cost per QALY of β-interferon varied by a factor of 100. Further modelling commissioned by NICE resolved the estimate to a range of between £35 000 and £339 000 per QALY, depending on the assumptions used in the calculation.

Previous recommendations of NICE had established an acceptable cost of up to £30 000 per QALY, in line with previous suggestions that interventions with good evidence of effectiveness and costing up to £20 000/QALY should be given strong support.[18] Therefore, the treatment was rejected on grounds of cost effectiveness. (Estimates for some current interventions inflated to 1999 prices are £1500/QALY for hip replacements, £7500/QALY for breast cancer screening, and £27 000/QALY for hospital haemodialysis.[19])

**The plot thickens — a new chapter in rationing emerges**

Rather than rejecting the drug outright, NICE took the unusual step of inviting the Department of Health and manufacturers to consider what actions could be taken jointly to enable medications to be secured for patients in a manner that could be considered to be cost effective. No reason was given for this caveat except the uncertainty over which individual patients would benefit from the drug. The lid of Pandora's box had been prised open.

In response, the Department of Health, the MS Society, and manufacturers have developed a scheme whereby an estimated 30 000 patients will be assessed, of whom approximately 9000 would benefit from treatment. These patients will then be followed up on a continuing basis and prices will be negotiated with the manufacturers, such that the threshold for cost effectiveness is set at £36 000 per QALY.[20] The costs of treatment are estimated to be in the order of £50 million a year but the extensive resource implications for already overstretched neurology services have not been fully evaluated over the projected ten-year study.

**What does it all mean? Back to implicit decision making**

There are a number of important insights that arise from this case study.

First, it highlights the limitations of evidence-based policy making. Short study duration and limited experiment objectives will inevitably limit an understanding of the relationship between cause and effect, particularly in chronic diseases where many new interventions are being developed. The unusual design of the proposed observational study and its interplay with cost as outcomes emerge challenges the integrity of current research methodology and may be an unhelpful precedent for the future.

Secondly, the decision by NICE demonstrates that, despite contested methodology, analysis based on the QALY can offer useful 'ball-park' insights to facilitate the allocation of limited health care resources from the perspective of efficiency.

Thirdly, it confirms that rationing remains embedded within a political process. Powerful voices still prevail — the MS Society has a strong lobby and the UK pharmaceutical industry is an important part of our economic base. The implications of legal challenge from these stakeholders may also be an important political consideration. In the UK, blanket bans on treatment are illegal and may be challenged on the grounds of contravening the European convention on human rights. Unfortunately, there is little organised fuss from my elderly patients over their long wait to see the chiropodist, arguably one of the most cost-effective interventions in primary care.

**Conclusion**

This case demonstrates that, despite the rhetoric, explicit rationing remains politically unacceptable. Health care remains a complex system of conflicting values and competing policy objectives. Against a background of historical precedent and limited room for manoeuvre, most decisions are bargains reflecting the strength of competing stakeholders. After a short-lived honeymoon, we have returned to implicit decision making. For example, direct implications of this case will be longer waiting times to see neurologists, who will have less time to spend with other patients. Indirectly, other services will be cut to accommodate the demands of the proposed scheme — a return to rationing by delay, deflection, and dilution. Local decisions on how this should be done will vary leading to 'postcode' inequity. Rationing has simply been shifted to other areas of care that have a lower public profile.

The failure of explicit rationing should come as no surprise. International evidence suggests that there is no convergence to workable solutions that are acceptable both publicly and politically.[21] No ready-made framework exists for delivering priorities[22] and value judgements; estimates and gut feelings remain the predominant determinates of outcome.[23]

Lipsky[24] has described how front-line public servants — 'street-level bureaucrats' — implement policy faced with competing objectives and inadequate resources by manipulating explicit guidelines. In doing so, the devices they use to cope with paradox and ambiguity become the policies which help the system survive. Historically, rationing in the NHS has always been a process of 'muddling through' and currently, there seems to be little evidence to suggest otherwise. The games that are being played are not just at street level.

Political, cultural, and social elements will inevitably be integrated into the decision-making process. But with the rapid development in healthcare technology and the expanding array of therapeutic options, there will only be a finite capacity for the system to accommodate implicit rationing. Ultimately, the inability of government to make difficult decisions within the context of a finite budget will place untenable demands on the system.

One option would be to remove rationing decisions from government to an agency that is tasked to prioritise decisions within a fixed budget, recognising that solutions can only ever be partially satisfactory. To leave decisions to responsible and well-meaning groups of individuals who reflect the views of all stakeholders and are conversant with the available evidence, equity concerns, and public input, but sympathetic to the complex and conflicting environment in which health care is delivered. As Weale reminds us, 'To suppose that we can escape the dilemmas of rationing by retreating into a simple world where values are redundant and technical fixes abound is to cast a veil of deceit over the choices that must be made'.

Only one thing is certain. When price and the ability to pay are rejected as rationing mechanisms, there are going to be no easy solutions to who gets what and who goes without. But at least we should struggle honestly with our uncertainties.[25]

**David Kernick**

## in brief

At the *BJGP* we get some fairly dull texts to review, but only rarely something that is genuinely dangerous. Like ***Natural Medicine: Instructions for Patients*** (Lara U Pizzorno, Joseph E Pizzorno, Michael T Murray. ISBN: 0 44307128 4).

Take streptococcal pharyngitis — 'Fever is a natural immune defense mechanism and should be supported, rather than suppressed with drugs ...' Oh, really! 'We recommend using antibiotics only for those with a prior history of rheumatic fever or strep-induced kidney disease, those suffering from severe infection, or those who are unresponsive after one week of natural therapies described below', including 'zinc, the most critical mineral for immune function', and 'juice of aerial portion of *E. purpurea* stabilized in 2.2% ethanol: 2–3 ml'. And so on, through the usual litany of celery stalks and high potency multiple vitamin supplements. Asthma, apparently, is more likely 'after pertussis vaccination'. 'In one double-blind study of 18 patients...' just about sums it up. This nonsense is the normal stomping ground of the *National Enquirer*, or *hoolet*, and can be ignored. But *Natural Medicine* is an Elsevier Science/Churchill Livingstone publication, along with the *Lancet*, and they should be properly ashamed of themselves.

BMJ Books, on the other hand, can be commended for ***Clinical Evidence, Mental Health*** (ISBN: 0 72791745 5). Properly useful, though falling quickly out of date — wherein up-to-date guidance on fatigue, for example? Meanwhile OUP's desperate attempts to publish books that don't split on opening succeeds triumphantly with the ***Oxford Handbook of General Practice*** (Chantal Simon, Hazel Everitt, Jon Birtwistle, Brian Stevenson. ISBN: 0-19263270-1), which boasts a very nifty plastic cover. An outstanding and useful text, *de rigeur* for young registrars, and road-tested successfully by this less young Lanarkshire reviewer who now needs to get his eyes tested — the typography isn't huge.

And on the subject of road-testing, seek out ***Car Culture***, by David Cotterell, at ***Beck's Futures 2002*** (CCA **Glasgow** until 22 September, then Mappin Art Gallery, **Sheffield**, until 4 January 2003) — video footage of motorists attempting to overtake the artist's car as it travelled from London to Glasgow, at an unrelenting 70 mph, in the outside lane. Of particular interest to the drivers of S446 TNP, S635 MLT, Y463 DRU, and ten or so other psychotic vehicles. The writhing traffic is curiously balletic, an effect enhanced by the booming soundtrack, Stravinsky's *Rite of Spring*. Worth going to see.

***Alec Logan***

**Serious: the autobiography**
**John McEnroe (with James Kaplan)**
July 2003, Little, Brown (An imprint of Time Warner Books UK)
HB, 346pp £17.99, 0 31685986 9

The rule of thirds applies, though only if we can bend the rules and make the third third into one one-hundredth. The first third wrinkled their nose at the title of this piece and thought "Horrid little man, I never liked him". They have already discarded themselves. The second group, who may actually still be reading, loathed the subject during the time when he was doing the thing for which he was supremely gifted, but have warmed to him now that he is one of the few tennis commentators who does not sound as if he's nostalgic for the good old days of fagging and rumpy-pumpy in the showers at Eton. Or, as my wife kindly puts it, one of those monotone Americans spouting percentages and platitudes.

This review is written unashamedly for the remainder.

The remainder almost seem to describe themselves using the language of Myers Briggs personality tests. Like McEnroe, they are 'feelers' rather than 'thinkers', they are incapable of hiding emotion to the same extent that Iain Duncan Smith is capable of exhibiting it. They are dreamers, idealogues, polemicists. They do tend to have a thing about authority figures.

Until I actually had children, my preferred name for John Patrick McEnroe was 'my son'. Not, you understand, in the Essex manner, as in "Gaw on ma' saahn", as screamed at vulgar footballers. But despite the age incompatibility, I actually considered McEnroe to be an element of my persona. His battles with authority were mine, his flamboyant, apparently effortless genius the thing I most admired (sadly).

Well, the book contains some surprises, the first of which is that, unlike Madame Piaf, he appears to regret quite a lot. On reflection this is compatible. The sportsman/artist who to the greatest extent in recent history exhibited most of himself (I do not count minority interests such as Tracey Emin), warts and worse is now doing the same thing, except in a grown up *mea culpa*, reflective, literate kind of way.

The unacknowledged flaw — and it shines out from the book — is his thing with women. His mother is mentioned only a handful of times, and never with flattery. Perhaps she really is a monster. He is ridiculously grudging about the Williams sisters (though they are obviously rather good at defending themselves), distinctly on the defensive over Tatum O'Neal, and the thing he appears to admire most about the legendary Patty Smyth, whom he describes as his soul mate, is her capacity to give up her entire career to look after him and his extraordinary profusion of children without moaning too much. He takes credit for an occasion, when his partner and nanny are unavailable, of getting out of bed to change a nappy. The words 'cake' and 'eating it' come to mind. He uses an unconscionable expression about Steffi Graf, even before that TV advert for some mobile phone network or other.

Best therefore to remember the tennis. Here his memory is better than mine. I remember his first Wimbledon win though, and in similar terms — neither of us apparently could see him winning it until, lo and behold, Borg handed it to him on a plate. I also recall a mental picture of him advancing to receive the service of Connors, or somesuch, until he was forced to take it almost on the half volley. The magic of that low trajectory and the way it found angles unimaginable, at speeds unthinkable, will be his abiding place in my recall. The certainty of his volleying, also his athleticism, his 'wiryness', like a stick insect with attitude, and his emotional rawness make him, to my mind, the most watchable tennis player ever. I did also like and admire his appetite for rowing with officialdom, which even he now concedes was to most minds reprehensible. Some will therefore think it over-sentimental of me to see in him as a precursor to the classless, undeferential, questioning mindset which is now considered received wisdom in the consumerist post-modern age.

His reflection on his peers surprised me. Not that he evidently loathed (and was loathed back in spades by) Jimmy Connors, which is all too obvious, but his love affair with Bjorn Borg came as a shock. No-one else in the book is described in such unqualified positive terms, and yet they were as different on a tennis court as poles of a spectrum. There is a great story of McEnroe having a tantrum in one of their games at 5-5 in the fifth set. The Swede beckons him to the net, puts his arm round him and quietly exhorts him to "relax, after all it's a great match".

One can only be shocked that McEnroe did not floor him, but for once the respect for his combatant overcame him.

Being American, he is naturally haunted by the 11 September 2001 — indeed the book starts here. After all, he was in New York when it happened, as were his family, but all in different places. This scenario is all too terrifyingly imaginable. Alongside this is his nationalistic fervour, which this author found less sympathetic. He is impressed by people — the old fraud Jack Nicholson ("Never change, Johnny Mac") and umpteen minor rock stars and politicians spring easily to mind — of whose motivation he might have been more suspicious.

Nonetheless, his crowning non-matchplay tennis achievement is one for which he deserves genuine credit, namely his refusal to take the exorbitant bait to play tennis in Sun City while it was only nominally a state free from the apartheid regime in South Africa. For this he was rewarded by special praise from the man most deservedly in receipt of praise in the world, Nelson Mandela. The thought of Mr Mandela, like me, listening to McEnroe's historic first Wimbledon win — in different circumstances admittedly: he in jail on a transistor, me on my sofa in Yorkshire on colour TV — both loudly cheering him on, is an image I can savour and is almost itself worth the price of the book.

So, in summary, John Patrick McEnroe is a flawed but human figure. His major flaw is vulnerability to self doubt, and his major characteristic the transparency of his emotion. For this, and the romance of his unique contribution to tennis, his admirers and some who have sometimes fallen short of admiration, may enjoy and cherish this book. It is honest, self-effacing (not always convincingly) and frank, though inevitably it is the times when frankness is eluded that grab the interest. For the record, I decided that the unnamed famous older woman with whom he had a brief but intense affair was either Katherine Turner or Sigourney Weaver. But sadly, reader, this tells you more about me, and less about the writer of this autobiography.

***David Tovey***

**Year of Wonders**
**Geraldine Brooks**
April 2002, Fourth Estate
PB, 320pp, £6.99, ISBN: 1 84115458 X

THE bubonic plague is thought to have originated in China. Brought to the Western World by Italian traders, it killed one-third of the population of Europe between 1347 and 1351. It persisted sporadically until another major epidemic in England in 1665. The 'Black Death' took the lives of at least 100 000 Londoners in one fateful summer. Plague had a short incubation period, leading to massive lymph node enlargement (buboes), and a haemorrhagic rash. In virtually every case the victim perished, sometimes only hours after onset of fever.

*Year of Wonders* is based on the true story of a lead-mining village in the Peak District in which there was an outbreak of plague in 1665 — carried, it is thought, by fleas in a consignment of cloth from London. As Derbyshire was then otherwise free of the scourge, the villagers were persuaded by their priest to forego contact with the outside world and stop the spread of the disease. It is historical fact that the villagers remained in quarantine and, by the following spring, only a dozen or so of the original inhabitants remained alive.

Their story is narrated by the educationally aspirant serving-maid of the rectory. She lives through her own tragedies and then those of the rest of the village as she accompanies the vicar and his wife in their ministrations. As the book starts at the end before tracking back, there is a predictability with which we read of these deaths. I'll weep easily enough at a book, but not with this one, perhaps because no death is unexpected and, along with the heavy ore, there runs a thin seam of mawkishness.

As a social history, the book is fascinating. Although the Enlightenment was gathering pace in Europe, the village of Eyam was still in the Middle Ages — with the church as the focal point of a highly interdependent community which had never looked far beyond itself. We learn about the lead mines and the rules that governed them, about Puritans, the 17th century diet, country trades, and how a village takes care of its social needs without state interventon.

And what of the medical profession in it all? The physicians and surgeons, like the aristocracy, are portrayed as ineffectual and self-serving — their power derived from their positions rather than from their ability to do anything useful. Then, as now, anyone with money and influence keeps well away from the places where the human need is greatest. The characters in the book who do the most medicinal and obstetric good are the women who preserve the herbal lore and pay the highest price. Again, with parallels to today, these lay healers harvest the contempt of the professionalised classes along with their roots, worts, and seeds.

It's been said that the modern GP is like the priest of olden days: confessor, comforter, and companion for the journey into death. Fanciful perhaps, but in *Year of Wonders* it is the priest who is called in exactly the same way that we would now call the doctor — when things are looking grave. As humans we need some clear points of reference. The rector also suffers many of the travails of the old-style single-handed GP, with nobody to share on-call, discuss misgivings or question his judgement. He is eventually consumed by his own ardour; that is, he suffers burn-out.

This is a book that might inspire faith in people, but not in God for, despite the (well-intentioned) zeal of the priest, the pews gradually empty and the church congregates in a field to avoid contagion. The desperate, simple people kill their own as witches, but themselves fall under the spell of superstition, depravity or religious fanaticism.

There is a poignant section in which the narrator comes close to narcotic oblivion as an answer to her emptiness and grief. As a study in addiction, or its close evasion, it rings true for today. The weeds of dependence grow in the soil of dereliction and despair. But with help people can choose life over oblivion. The novel also carries a love story of subtle complexity which gathers pace in the final chapters towards a rushed, and some might feel incongruous, conclusion.

Modern medicine has answers for the plague. We know the organism, we know the vectors, we know the cure and we know it has nothing whatsoever to do with God. Yet it was religiously inspired altruism that staved off the death of thousands in the Midlands. And if such a sacrifice were needed today, who would make it?

This is an evocative novel, thoroughly researched and with a clever voice. On one hand, reminding us of something lost, an interconnectedness and sense of place and right pace; on the other, of the intense insecurity of life and some of the progress we have made to shore that up. Well, here at least, for tens of millions across the world there are other plagues being faced right now.

***Trevor Thompson***

## London Open House Weekend

LONDON Open House weekend (21 and 22 September 2002) is a wonderful idea and great fun. Part of the annual festival of European Heritage Days, held all over Britain and continental Europe every September, the two days celebrate architecture in every form. Venues are free to all visitors. Nearly all London boroughs participate in the scheme and over 500 sites are listed in the free programme available from libraries, tourist offices, and on **www.londonopenhouse.org**. The range of sites is enormous: new and old churches, cemeteries, office blocks, industrial sites, galleries, museums, and individual homes. Though many are open all year, quite a few are not usually open to the public — and these are the most interesting.

Careful study of the programme is essential. There is an index, but a glance through the individual borough listings is more useful. Not all venues are open over the two days: some open only for a few hours on either Saturday or Sunday, some have to be pre-booked, and others have tours at specified times.

The bigger sites do benefit from a guided tour, such as the Old St Pancras Hotel. Built in 1873 by Gilbert Scott as the Midland Railway Hotel and offices, its fairytale exterior is well known, but the interior is not, since the hotel was closed in 1935 and the building itself in the 1980s. There is now a preservation society whose members take visitors round in groups. Industrial sites also benefit from having a guide. Among the couple of dozen in the programme is the restored watermill at Bromley-by-Bow, built in 1776 to mill grain for the distillery trade and operational until 1940. Others of interest are the Kew Bridge Steam Museum, the Brunel Engine House, and the Abbey Wood Powered Generator (Thames Water).

Children of all ages love the working exhibits. Nearly all open houses have information leaflets and/or displays. The most interesting site I visited was one where there was nothing to see! This was the Bishopsgate Goods Yard. It is amazing how people will give up a Sunday afternoon to scramble over six acres of debris in the near darkness, but it was fascinating to hear how the Victorians brought in market garden produce from one part of the country and wheeled it across the platform for a train to take it to another region. There are plans to develop this under-the-arches site into workshops, studios, and facilities for the local community.

Medicine is always well represented. The dozen or so hospitals and clinics listed include the new (1993) Chelsea and Westminster Hospital, with its excellent display of art throughout the building, the 17th century almshouses of the Trinity Hospital in Greenwich, and the Royal Hospital (by Wren, Hawksmoor, and Vanbrugh) — the home of the Chelsea Pensioners. The Trinity Hospital in Greenwich faces the riverfront and is completely dwarfed by an enormous power station. This gives the almshouses a wonderful sense of seclusion and accentuates their smallness. The buildings were restored in 1812 and 20 lucky male pensioners live there, surrounded by a wonderful garden — so unexpected in a built-up area. There is also the new NHS group practice, built next to the Hammersmith flyover, which won an architectural award, as well as the Pioneer Peckham Health Centre, built in 1935 and now converted to private homes, though you can visit the grounds and the communal areas. The Royal Colleges of Pathologists and Surgeons open their headquarters every year, as do the BMA and the Wellcome; and in September this year, as part of our College's 50th anniversary celebrations, 14 Princes Gate will be open as well. We hope that many people will visit.

**Margaret Hammond**

**A Broken Landscape: HIV & AIDS in Africa, by Gideon Mendel**

The Side Photographic Gallery, Newcastle upon Tyne, and Halifax (24 August–10 November)

THE first thing that struck me about this exhibition was the photographer's Jewish name. It seems appropriate for a Jewish person to document the human effects of the AIDS holocaust that is slowly killing tens of millions of people in sub-Saharan Africa. In the year 2000 alone, 2.4 million died. The images of this broken landscape evoke recollections of the Nazi Holocaust, with the same emaciated bodies and gaunt faces, albeit black rather than white.

The photographs, taken over seven years in South Africa, Zimbabwe, Malawi, Zambia, and Uganda, are fine black and white prints. There are no fancy photographic tricks, just simple, unobtrusive, well composed portraits and scenes. They come with short personal testimonies that bring their subjects to life: 'I have been sick for ten years now ... my life is rich. I have no pain. My belief in God makes me happy and I have the love and care of my family'. The social context is made almost unbearably real. We see a grandmother, whose eight children have all died of AIDS, struggling to care for her grandchildren. A mother visits her daughter in hospital. They are smiling in the picture. Self-help groups try earnestly through stories, drama, and exhortation to change the sexual behaviour and gender roles that encourage the spread of AIDS. A man states he does not want to use condoms — he likes to feel 'flesh to flesh' when he has sex.

In short, this photographer's art engages one's attention and emotions, and provokes deep reflection, not only about the immediate subject matter, but about the human condition in general.

The Side photographic gallery is run by Amber, a collective that has been documenting the life of working class communities in the north-east of England since 1969 through photography and film. It also brings international exhibitions, such as Mendel's, to the region. It is one of Newcastle's cultural jewels.

**http://www.amber-online.com/**

***Toby Lipman***

**Left:** Joseph Gabriel carried by his mother Dorika. Mwanza, Tanzania

*Photo courtesy of Gideon Mendel/Network Photographers*

*Broken Landscape* by Gideon Mendel is published by Network Photographers in association with Action Aid, price £19.95

# roger neighbour *behind the lines*

I'VE been stung by a wasp, and its name was H L Mencken. Henry Louis Mencken, to be precise; 1880–1956, American humorist, critic, and columnist in the *Baltimore Sun* during the prohibition years of President Hoover and Roosevelt's subsequent attempts at social liberation, the New Deal. Had he been spared, HLM would have been a regular contributor to these Back Pages, being a man with a needle-sharp pen who couldn't see a balloon without wanting to prick it, sanctimony without wanting to laugh at it, or a generally accepted opinion without wanting to poke it in the eye. This sort of thing:

*'We must respect the other fellow's religion, but only in the sense and to the extent that we respect his theory that his wife is beautiful and his children smart.'*[1]

Or: *'Who will argue that 98.6 Fahrenheit is the right temperature for man? It may be that we are all actually freezing: hence the prevailing stupidity of mankind. At 110 or 115 degrees even archbishops might be intelligent.'*

I wish (Madam President, Officers, Members of Council, fellow subscription payers) to nominate this most waspish of cynics for honorary, if posthumous, Fellowship of our College. In my citation, may I quote from some of Mencken's sideswipes at the role and qualities of the family doctor, reminding you that he was writing before the discipline of family medicine — as we currently understand it — was recognised in this country, let alone in his native USA?

*'Very little of the extraordinary progress of medicine during the past century is to be credited to the family doctor, though he is still the official hero of the craft ... The current sentimentalising of the old-time family doctor is mainly buncombe. In 99 medical situations out of 100 it is of no advantage to a doctor to know his patient intimately. The idea that a doctor should be a family friend flows out of the prevailing delusion that most illnesses are largely psychic … The specialist is more effective, having seen the situation a great many times and being familiar with its variations. The GP can at best have seen it only a few times, and his memories of it are blurred by a crowd of memories of other situations, some of them deceptively like it.*

*'All the errors that lead to burst appendices are made by family doctors who are supposed to know the patient inside out. While they gossip with him, with occasional glances at his tongue, and inquire about his mother-in-law's asthma, his burst appendix is pouring pathogenic organisms into his abdominal cavity.'*

Resisting the temptation to wonder what botched encounter with a hillbilly sawbones provoked HLM's urge to bite the hand that palpated him, and separated though we are by two generations and the Atlantic Ocean, we might ask ourselves nevertheless, like a dog returning to its vomit, whether his tired old obloquy doesn't still have legs after all.

Although we don't usually say it out loud, the proud but secret manifesto of general practice in the College's lifetime has been this: GPs' clinical competence is pretty much sufficient for the purpose; the defining virtues of the discipline are personal, integrative, compassionate. That bluff, if bluff it ever were, is once again being called by a new generation of neo-Menckenites in grey suits. But it's being called so insidiously, so reasonably, that we may well not realise we are in a battle to defend our speciality until the battle has already been lost. A Shipman strikes: 'He's unique!' we rightly insist. An appendicitis is missed: 'But managing uncertainty is an uncertain business,' we sagely maintain. The death rates from heart disease, cancer and diabetes, in shameful defiance of Government diktat, obstinately fail to plummet: 'The targets are irrelevant,' we protest; 'it's the fault of the individual, the advertising industry, society. If only we had more time, more resources …'

And all the while the neo-Menckenites — briefcases bulging with calculators, spreadsheets and targets, and muttering 'The only good doctor is a measured one' as they position themselves for the pounce — are corroding the gilt of our self-esteem with the *aqua vitae* of mensuration. That their faces bear the smug smiles of those who believe that to be elected once is to be right forever should not reassure us. We should be in no doubt: the lucre promised shortly to rain down upon us is scheduled to bring about, not a new golden age of general practice, but a chromium-plated one.

So why should the waspish Mencken be a hero for our age? For alerting us, as did the honking geese on the Capitol of Ancient Rome, to the stealthy approach of enemies.

**Reference**

1. This and other quotations are from Mencken HL. *Minority Report*. Baltimore: The Johns Hopkins University Press, 1997.

## *BJGP* online — 'if at first you don't succeed ....'

**Introduction**

It's been talked about for so long that it's easy to convince yourself that this is the end, and not the beginning. Finally, after a three-year long cycle of research, planning, financial upheaval and disappointment, we're ready to launch the *BJGP* fully online during National General Practice Week (23–29 September), giving all members and subscribers the service they deserve and quite a lot more besides.

There is no doubt that the absence of a proper web presence has been a serious handicap to the progress of the *BJGP* over the past few years. However, given that the journal's reputation for excellence must be maintained, we knew that it was crucial to get it *right* and, at the same time, be realistic about what we could achieve. We believe that we have now found the right combination of functionality, technical know-how, and business partnership to make the online *BJGP* a reality.

**Why has it taken so long?**

The project's wheels have been in motion since early 1999, when Deputy Editor Alec Logan began researching and negotiating with HighWire, to bring their extremely impressive and fully comprehensive service to bear on the BJGP's requirements. Part of Stanford University, HighWire's credentials were second to none: they are responsible for the *BMJ*'s website, as well as dozens of others of a similar profile. We felt that we were in good company — their proposal was costly, but with some negotiation it seemed manageable — and from the start it had unstinting support from everybody who cared about the *BJGP*'s future. But, after a time it became clear that the figures simply didn't add up, and the ongoing costs could not be sustained by the College. An alternative had to be found.

During the year that followed, the College was fortunate enough to take on board a new IT Systems Manager, Tony Betts. His huge contribution to the project has been largely unsung, but it is almost entirely due to his background in getting scientific literature onto websites and his inside knowledge of service providers within the industry, that we were able to take control of the tendering process and make informed decisions about what was technically achievable.

**The result**

We investigated a succession of companies and methodologies for their ability to give a cost-effective and comprehensive hosting service. Although the services on offer were wide-ranging, and the companies had some solid reputations built on well-known clients, none of them offered the degree of connectivity and ease of use that we were hoping to offer to our members. We even considered a DIY approach, in which the *BJGP*'s site would be designed, constructed, developed and maintained inhouse, either by our own staff or by a consultant. However, it became clear as time went by that such an undertaking was not a priority for the College's resources, and that external hosting was the only feasible route to acquiring the service we were hoping for.

Enter Ingenta. This will be a name familiar to those of you who search for literature or use your library's subscription to journals using Ovid or CatchWord. A well-established company that seemed to offer a genuinely client-friendly approach to site building and hosting, we were immediately impressed by their flexibility — and their willingness to work with our agonisingly slow decision-making processes!

**On-line access**

What can members and subscribers to the *BJGP* hope to receive when the service is launched? Although the site is hosted by Ingenta, it is also brought to you via the gateway of the College's own website, so you can easily jump to the site after entering the Members' Area. Alternatively, you can enter directly through Ingenta's own site.

Once in the site you can search current and past issues within this year's volume, and you will discover that many reference citations will be hyperlinked directly to the cited papers themselves. You'll be able to search right across all of the journals hosted by Ingenta, as well as archives of *BJGP* volumes going back to 1999. We are still in the process of building our archive — next year we will have the 1996, 1997 and 1998 volumes online. There will be Table of Contents alerting, and in the future, we fully intend to expand our output, by publishing additional papers on the website that do not appear in the printed journal.

We are very excited and pleased to be able to bring the *BJGP* online in this, the RCGP's Golden Jubilee Year, and we hope that it will become an indispensable tool for all general practitioners, whether or not they are members of the RCGP.

**Lorraine Law**

## 11 September 2001 ....

AFTER the shock to the Western World from the heinous attacks on the World Trade Center and US national fortresses there were few voices to be heard that attempted to explain such human behaviour. Who could do such a thing, and why? Stigmatising the terrorists as hostile religious zealots helped to justify military action and compel allies to pass anti-terrorist laws. Meanwhile, a war has been fought and there are more to come.

But to analyse the developments in world politics leading to the events of September 11 we have to ask why people are prepared to kill thousands of human beings and why they are desperate enough to sacrifice even their own lives? Do they see no other way out of the cul-de-sac of their peoples' situation? As physicians, we counsel our patients in coping with their psychosocial problems, trying to understand them in the light of their respective socio-political backgrounds. This strategy was applied by the well known psychoanalyst Erich Fromm, who observed that economic, political, and ideological forces mould social conditions, which in turn shape the actions of individual persons. In *The Heart of Man* and in *The Anatomy of Destructiveness*, Fromm distinguishes several kinds of aggression and violence. He describes 'malignant aggression' as instinctual, and develops a theory that serves as a rationalisation for violence commited by people overwhelmed by fears and the feeling of impotence. This feeling of powerlessness, induced by the continuing game of superiority and inferiority played by political opinion leaders of the western world is, I feel, one of the most important engines driving terrorism. The superiority–inferiority game includes economic exploitation and suppression by the Western World. Fromm warned us as far back as 1976 that:

*' ... The gap between the rich and the poor nations must be closed … What will happen, if we do nothing to eliminate the gap? Either epidemics will spread to the fortress of the whites or the poor nations will be driven by starvation to such desperation that they, perhaps supported by sympathisers in the industrialised countries, will commit terrorist acts, possibly using nuclear or biological weapons, triggering chaos in the fortress of the whites.*'

This much-read statement, outdated as the language now sounds, has proved strangely prophetic. Unfortunately no-one listened at the time.

**Wolfgang Spiegel**

## neville goodman

### Holding the baby

IF you want, in microcosm, the central failing of evidence-based medicine (EBM), take the example of stillborn babies. Maternity units have good practice guidelines; mothers are encouraged to see and hold the baby. Inevitably, if this is 'good practice', some mothers will be cajoled rather than encouraged. The guidelines were set up on theoretical grounds, and there is nothing wrong with that.

What theory suggests, clinical evidence supports or rejects. A good thing about EBM is that it encourages the testing of theory. A study (*Lancet* 2002; **360:** 114-118) now shows that mothers are least likely to suffer depression and other psychological sequelae if they do not see the baby, more likely to suffer if they do, and most likely to suffer if they hold the baby. In round figures, mothers who held their babies were five times as likely to be depressed.

It is easy now to scoff at the theory, as touchy-feeliness gone mad, and to say, 'There, I told you so! It was always a daft idea to force newly-bereaved mums to cuddle a dead baby.' But the study did not say (and nor did the authors pretend) that a mother who sees and holds her baby will be more depressed; it said only that mothers are more likely to be depressed. Herein lies the whole skill and judgement and art of clinical medicine.

Some mothers will want to hold their babies; some will not. If the study's findings are generalisable, then more mothers will not want to; however, if you now formulate guidelines on the basis that mothers should not be encouraged, there will be some mothers deprived of something that they, but not the average mother (who does not exist), would be helped by. The skill and art is knowing which mothers will be helped and which will not, knowing who to encourage and who to discourage. And for that, evidence-based medicine is completely useless; what is needed is experience, lots and lots and lots of experience. The guidelines would still be wrong even if the study supported the original theory, unless it showed conclusively that all mothers in a genuinely generalisable sample were less depressed after holding the baby. Otherwise, there would be mothers who would not wish to, and who would be harmed by doing so.

And the same is true for many of the conclusions of EBM. Mothers — patients — do not behave as random samples; they actually differ one from another. The trick in clinical medicine is spotting the differences. It's not easy, and it doesn't come in recipe books.

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**James Willis** remains feisty...

## james willis

**Telling grandma…**

'Do you use your spy-hole?', I asked the old lady who had just opened her door without checking who I was.

'No.'

'You ought to.'

'I ought to do an awful lot of things, but I don't.''

That makes two of us, I thought, jotting down her words as I sat down in her room. There are an awful lot of things I should do but I don't. And an awful lot of things I want to do, but I can't. I think this phenomenon should be called the 'should-do/do-do, would-do/could-do split'. Like a tectonic fault line, the 'SD/DD,WD/CD Split' (for short) ranges across the landscape of the modern world, separating our wonderful intentions from what actually happens.

For example: my morning routine has become even more of a nightmare. I now have an electric toothbrush which times me. Have you ever heard of a time-and-motion toothbrush? I have one. I push it about for two minutes, not a second less, then it shakes my hand, 'That'll do', it says, 'On with your life.' Two minutes, night and morning, three hundred and sixty five times a year, adds up to one thousand four hundred and sixty minutes. Which, by a happy chance, is almost exactly a whole day and night per year. Just brushing my teeth! I always knew that teeth ought to be brushed for two minutes, but actually doing it is playing havoc with all the other things I know I should be doing every morning, like checking my car tyres for embedded stones.

The 'SD/DD,WD/CD Split' separating our good intentions from our actual behaviour is inherent in the way we perceive the world and essential for the continuation of human life. We all have these wonderful plans, and we know that we really ought to do them, but, like my naughty patient, we don't. She knows how to suck eggs, but she doesn't do it that way all the time, or at all. She strikes a compromise which balances a myriad of things she wants to do — and which takes a refreshingly realistic view of the hazards she faces living in our cosy little town. Especially if, as I suspect, she recognised my knock on her door.

'I know I really should do it — but I don't.' Here we have a common-sense recognition that the proper use of new, improving ideas is to fine-tune our portfolio of priorities, not to crash in and dominate the ones that don't happen to be the focus of attention at the moment. New ideas always seem disproportionately important, that is why sensible people use them to inform and advise, without rolling over and allowing themselves to be bound hand and foot by every one that comes along.

We should be particularly conscious of the should-do/do-do, would-do/could-do split when we are seeking to impose our ideas on other people, especially on everybody else at once. People often agree that centrally-initiated ideas are good and important. But at the same time they forget that, in practice, things slip much more than we expect, or than we think they ought to slip. So, if people can't be straightforward with themselves about this phenomenon in their own experience, how much less can people at the centre see it, when their careers depend on the successful implementation of the change in question, and when they are required to blinker themselves from everything else that is the tedious concern of ordinary people?

And now the centre has the tools— like my toothbrush — to time, to measure, to count, to ensure the meticulous implementation of every single one of its wheezes. Grandmas must now suck eggs according to National Frameworks, in exactly the right way, at exactly the right time and in exactly the right place. And those directing from afar will be last to see the mess. Last to see the clever, technical bridges stretching and thinning as the landscape steadily divides.