

The Back Pages

viewpoint

Care or control in the community?

RECENT events in Soham have drawn attention to some of the more negative aspects of British society: the resurgence of national mourning sickness, the actual violence of mob rule, and the instinctive linking in many peoples minds of mental illness with violence.

The evidence base on violence and mental illness, however, tells a different story. Less than 10% of serious violence, including homicide, is attributable to psychosis,¹ with factors such as male sex and youth contributing a much higher proportion to societal violence than mental illness. Indeed, statistically, there is a greater chance of winning the national lottery than being killed by a person with a mental illness.² Yet Not In My Back Yard (NIMBY)-ism is rife and mental health service users, particularly those with serious mental illness, continue to live in communities that stereotype them as unemployable and potentially dangerous.

The tensions between controlling potential dangerousness and providing care in the community for mental health service users have also been highlighted by recent debates over the draft Mental Health Bill,³ which was open for public consultation for 12 weeks this summer. Although the draft Bill includes patient safeguards, such as rights of appeal and access to advocacy services, it also uses such loose criteria for compulsion and such a broad definition of mental disorder that people with epilepsy, multiple sclerosis, and substance dependence could fall within its remit. The blame culture within the National Health Service (NHS), coupled with such broad legislation, makes it likely that the number of people admitted under section as inpatients or with community teams will increase, adding to the stigma and loss of self esteem associated with mental illness. Compulsion in the community may also work against early detection of mental illness, with people too scared of the potential consequences to discuss mental health problems.

The draft Bill also suggests that, in certain circumstances, principles such as patient involvement in decision making and imposing the minimum level of intrusion can be disapplied. Indeed, as it currently stands, hundreds of people with personality disorder could be detained, even though they have committed no crime. This raises serious concerns about the balance between public safety and the human rights of mental health service users. It also seems at odds with an NHS that espouses a philosophy of empowerment and partnership⁴ and increasingly legislates for greater user involvement in health care.⁵

Primary care needs to take heed of these debates and their consequences in terms of new legislation, since they have significant implications for the way in which people with mental illness will be treated for the next 20 years. More positively, they also provide a stimulus to reflect on our ability to address the fear and stigma that surrounds mental illness, through our attitudes and actions at an individual and practice level.

Good professional practice includes recognising professional power and avoiding its abuse, by making our relationships with all users as collaborative as possible. Regarding patients with serious mental illness, it additionally means recognising the contradictory imperatives of care and control that operate, and developing honest relationships as our patients advocates, where issues such as illness, early warning signs, and relapse strategies are discussed openly and agreed in advance.

It means we need to understand the disproportionate influence of unemployment, poverty, and social exclusion on the lives of many patients with serious mental illness and move beyond a reactive sick note and procyclidine mentality towards more proactive care, perhaps signposting to re-training opportunities and to local Citizens Advice Bureau services. It might mean encouraging and supporting patients to make their voices heard in the new Primary Care Trust patient forums. Perhaps we need to remind ourselves that we can address some aspects of stigma, simply through challenging our own fears and by holding hope of recovery.

Helen Lester

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“You can be the sort of person that nobody will ever dislike, and nobody will ever remember. Or you can be the sort of person that some will certainly dislike, but whom others will love”.

Paternal advice from Paul Freeling, page 964.

“We were second-class citizens and again in those days [prior to the 1970s] it was not uncommon for GPs to be talked down to...”

Paisley doc Gerard D, on the changing relationship with secondary care, page 956

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Database of Individual Patients' Experiences — an update

THE broadcaster John Peel introduces the DIPEX colon cancer site, www.dipex.org like this:

Imagine being told you have a life-threatening illness you've never even heard of.

Imagine that you're at home preparing supper for your family, the phone rings – it's your doctor. He says that, unfortunately, the symptoms you've been experiencing are indeed caused by a malignant tumour in your bowel.

Or imagine being told that, from now on, your bodily waste will have to be collected in a bag attached to an opening on your abdomen ... bowel cancer is a disease that's seldom mentioned, and whose symptoms often go unrecognised until it's reached an advanced state.

The DIPEX colorectal cancer website brings you the stories of ordinary people, of all ages and backgrounds, who have faced the challenges of living with this disease. You can hear them talk about their symptoms, diagnosis and treatment, how the illness has affected them and their families, and the ways in which it has changed their lives.

Perhaps you or someone close to you has this disease. Maybe you treat or care for people with colorectal cancer. Or maybe you just want to understand more about this illness and what it's like to live with day after day.

We reported the launch of DIPEX a year ago¹ (*BJGP* 2001; **51**: 770). Since then it has grown remarkably. In March, modules on breast cancer and colon cancer were added. In December, cervical cancer, cervical screening and testicular cancer will be launched on a redesigned website that will be easier to navigate, will give more detail about the patients interviewed, and will have space for many extra resources. The redesign will also make it possible to update the site immediately. Feedback from users of the website has been very useful in guiding the redesign. A programme of evaluation is being planned, with patients, medical and nursing students, and clinical trainees.

Work is now in progress on epilepsy, rheumatoid arthritis, and carers of Alzheimer patients. Funding has been obtained from the Department of Health, cancer charities, the British Heart Foundation, and other charitable trusts for modules on ovarian cancer, sexual health of young persons, antenatal screening, parents of children with congenital heart disease, heart failure, lung cancer, and chronic pain.

Funding is being sought for modules on teenage cancers, the parents of children with cancer, smoking cessation, and major affective disorder.

One trained qualitative researcher with a background in medical sociology or anthropology is in charge of each module, finding the patients, interviewing them in their homes, and analysing and summarising what they say. The DIPEX team now includes six qualitative and health service researchers (including one working in Bath and another in Scotland), three doctors, and two administrators; the website is designed and maintained by Lion TV.

Each collection of interviews is a stand-alone qualitative study, as well as providing material for the website. These studies have been used to prepare papers on aspects of patients' experiences for peer reviewed journals for different groups of readers such as GPs, clinical specialists, sociologists, consumer advocates, support groups, and policy makers. Four papers have been or are being published on prostate cancer, including: Is watchful waiting a real choice for men? (*BJU International*); Why men with prostate cancer want wider access to prostate specific antigen testing (*British Medical Journal*); Prostate cancer: embodied experience and perceptions of masculinity (*Sociology of Health and Illness*). Three papers on testicular cancer have been written, one rather surprisingly about how important humour is to men with the disease. Papers on breast and bowel cancer are being prepared.

DIPEX is also beginning to develop an international aspect. A description of the project has so far been published in German, Italian, and Japanese, as well as English. Interest in starting DIPEX collections of interviews has been expressed in The Netherlands, Switzerland, Japan, Italy and Spain. We hope that DIPEX will eventually become an international collaborative database that will make it possible to compare illness experiences in many cultures and health systems.

We need to recruit patients from general practice for all the modules in preparation and for future modules. We need patients who are suffering from ovarian and lung cancer, melanoma, and heart failure, as well as teenagers with cancer, and the parents of children with congenital heart disease to take part. Please contact us if you would like to be part of the GP DIPEX network at dipex@dphpc.ox.ac.uk.

Ann McPherson
Andrew Herxheimer

WONCA Region Europe and Slovene
Family Medicine Society

**9th Conference of the European
Society of GP/FM – WONCA
EUROPE 2003: The Future
Challenges of General
Practice/Family Medicine**

CANKARJEV DOM, LJUBLJANA,
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<http://www.woncaeuropa2003.org>

This Conference will explore topics such as: Lifestyle Problems; Acute Problems; Communication with Patients; New Technologies; Quality; and Humour in Medicine. There will also be a wide variety of topics covered in the invited plenary lectures, symposia, workshops, demonstrations, freestanding paper sessions, and the poster exhibition. We look forward to welcoming you to WONCA Europe 2003 in Slovenia from 18 to 21 June 2003.

Janko Kersnik

*Chair of the Scientific Programme
Committee and Chair of the Organising
Committee*

Deadline for Submission of Abstracts:
14 November 2002

Early Bird Registration: 31st October
2002

On-site Registration: 18 June 2003
from 14.00 hours in the Congress Centre

Guest lecturers: Iona Heath (UK), Ethical Dilemmas in General Practice; Chris van Weel (Netherlands), Biological Limits to Medical Interventions; Branko Cesnik (Australia), Modern Technology in General Practice; Bernard Gay (France), Genetics as a Tool in General Practice; Barbara Starfield (USA), Primary Care: the Setting for Leadership in Quality of Care; Christina Fabian (Sweden), Equal Opportunities in Family Medicine.

Registration fees

Early Bird Individual Rate (payment by
31 October 2002): 478 euros
On-site payments: 690 euros

For further information visit:
<http://www.woncaeuropa2003.org>.

Queries regarding the Conference scientific programme: Ms. Ana Artnak, Department of Family Medicine, Poljanski nasip 58, pp 2118, SI-1104 Ljubljana, Slovenia. Tel: +386 1 4386915; Fax: +386 1 4386910; E-mail: kdrmed@mf.uni-lj.si

flora medica

From the journals, September 2002...

N Engl J Med Vol 347

716 No need to get into a sweat, at least if you're a woman: ordinary walking seems to protect the female heart as much as vigorous exercise.

781 If you are a chap of a certain age, you may wake up for a pee and not get back to sleep for worrying about radical prostatectomy. Here is a reassuring Scandinavian study – firstly, it's unlikely to catch on, because it has **no mortality benefit in early prostate cancer**; secondly (page 790) it doesn't ruin **quality of life** as much as you'd think.

869 The **hygiene hypothesis** – that many modern ills are the product of a clean early-life environment – receives a boost from a study of three German-speaking countries looking at the amount of **bacterial endotoxin** in children's mattresses. Sleeping with bowel bacteria seems to **prevent atopy**, rather like sleeping with a couple of pet cats or dogs (see last month's column). And we may not just be talking about hay fever, allergic asthma and eczema. On page 910, a discussion paper contains a fascinating array of geographical and epidemiological data about cleanliness in association with **Crohn's disease, multiple sclerosis, and type 1 diabetes**.

969 **Myocardial infarction** should be followed by indefinite **anticoagulation using warfarin** to get the best long-term outcomes.

Lancet Vol 360

743 And all **acute coronary syndromes** are best treated by **immediate revascularisation**, according to the **RITA** series of trials, the third of which is reported here.

825 Here too is more evidence of the superiority of **primary angioplasty** over very early (pre-hospital) **thrombolysis for myocardial infarction**, even though the investigators are reluctant to reach that conclusion. So are we on the verge of a complete change in the management of MI? Goodbye thrombolysis and aspirin, hello stents and warfarin? It certainly looks that way – see the editorial on page 814.

JAMA Vol 288

1245 **Carpal tunnel syndrome** – **open decompression beats splinting**, according to a randomised controlled trial comparing the two treatments. No mention here or in the editorial (1245) of that old British favourite – a few drops of steroid injected next to the median nerve.

1252 **'Brain' natriuretic peptide (BNP)** actually comes from the cardiac ventricles in response to stretch, and correlates much better with cardiac function and prognosis than echo measurements, such as systolic ejection fraction. But the tail was discovered before the dog, and people are still trying to use BNP to select patients for echocardiography, as in this **Framingham** community study, which looks to see if it would pick out people with asymptomatic left ventricular systolic dysfunction (on echo) or LV hypertrophy.

1388 Got your practice coronary heart disease prevention sorted? Good – then it's time to move on to **stroke prevention**, aided by this excellent review.

1403 How long do you tell your patients to take **antidepressants**? And how much do they remember? Big discrepancies are revealed in this US study – time, perhaps, to look at whether the six-month rule really has a primary care evidence base.

1447 Now that we're all about to be assessed, what are we going to do about all the **burnout** we discover? Get hold of this review if you're an assessor, a mentor, or just burnt out.

Other Journals

Arch Intern Med Vol 162: If **thrombolysis** becomes obsolete for MI, what about **stroke**? The tiny benefits demonstrated in trials are likely to be outweighed by complication rates owing to protocol deviations (page 1994). More International Normalised Ratios to look forward to: **warfarin** kept up for weeks after hip surgery reduces the chances of developing deep vein thrombosis (page 1966).

Ann Intern Med Vol 137: **Statins** can cause a myopathy without elevated creatine phosphate kinase (581). **Mammography** may be worthwhile in some groups (E347) but not at age 40 to 49 (E305).

Do you cheat when recording blood pressure? The *Quarterly Journal of Medicine* (95) has caught you in the act of terminal digit preference and shown that it can affect outcomes (571). In *Archives of Disease in Childhood* (87), the Archimedes pages carry simple guides to common problems, ending with the Bottom Line section – most appropriate in the case of Is perianal dermatitis a sign of sexual abuse? It isn't: take a swab and treat for streptococci (262). If **allergens** worry you, don't look in *Allergy* (57) – danger lurks in chrysanthemum pollen, snails, cypresses, dill, liquorice root, and playing cards bearing traces of peanuts. Time to consult a paper on Fuzzy recognition in the immune system (*Scandinavian Journal of Immunology*, 56[3]: 224).

Plant of the Month: Mahonia lomariifolia

This plant tries hard. It waits until the worst month to produce its sprays of scented soft yellow flowers on an exotic structure of evergreen leaves, both gangly and elegant.

Theophrastus Bombastus



Audio extracts from the interviews can be listened to as sound files on the SchARR website:

<http://www.shef.ac.uk/~scharr/hpm/IGS/>

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11. GPP 07.
12. GPP 15.
13. GPP 16.
14. GPP 04.
15. GPP 23.
16. GPP 15.
17. GPP 06.
18. GPP 02.
19. GPP 27.
20. GPP 18.
21. GPP 21.
22. GPP 04.
23. GPP 10.
24. GPP 02.
25. GPP 05.
26. GPP 15.

WHEN Joseph Collings conducted his survey of general practice in 1949 he actually met doctors who believe that they must do a certain amount of major surgery or lose the respect or faith of their patients.¹ Over two decades later, Frank Honigsbaum, in echoing Collings findings, provided one of the most powerful and influential critiques of the division of British medicine and its impact on general practice. Honigsbaum's analysis first came to the attention of family doctors in 1972 through an article entitled Quality in general practice, published in the *Journal of the Royal College of General Practitioners*.² As with the earlier Collings Report, the article generated a volume of hostile correspondence from GPs, causing the College to distance itself from automatic association with the papers published in its *Journal*.³

One indication of changing relationships in medicine is the confidence that working doctors have in their profession – a confidence that their predecessors lacked.⁴ And we would not deny that tensions between hospital-based and community-based practitioners have been evident since the formation of the NHS, as they were before. Yet, the oral evidence suggests that among rank-and-file GPs there was a more complex, nuanced, and less universally shared perception of the changing relationships between primary and secondary care.

Certainly there were some older practitioners who continued to recall with bitterness the removal of GPs in 1950 from posts in the local Royal Alexandra Infirmary (RAI). And some of Paisley's younger practitioners complained that, since 1990, their interaction with secondary care in general has deteriorated. However, the testimonies suggest that the town's GPs developed a strong link with hospital medicine in general and the local hospitals in particular. Connections were facilitated by the town's geography; Paisley was small enough for clinicians to know one another if they wanted to, but close enough for the Paisley hospitals to be bypassed in favour of onward referral to Glasgow. Hence it was in the interests of the local hospital doctors not to isolate themselves entirely from the GPs in their catchment area.

Members of the RCGP, along with colleagues on the LMC, jointly promoted training in Paisley, and in the 1960s and 1970s clinical meetings involving the hospital's consultants and local GPs were held at the infirmary. In addition, there was a series of less formal lunchtime meetings hosted weekly by the hospital's staff, which the town's GPs could attend. And, even more significantly, older practitioners recall being able to drop into the hospital without warning to enquire about a patient's progress.

From 1974 onwards the RAI provided a part of Paisley's first vocational training scheme for GPs. The Paisley scheme was somewhat different from others in the West of Scotland, offering six months in general practice followed by two years in hospital and a return to general practice for six months. It has been claimed that this popular, often over-subscribed scheme promoted closer working relationships between GPs and hospital staff. Although the general practice element tended to be somewhat squeezed, trainees felt that it was a good way of learning about different practices in the town from the perspective of the hospital staff.⁵

Increasingly, individual practitioners were also returning to sessional work as clinical assistants in hospital departments, including paediatrics, anaesthetics, psychiatry, and dermatology. There are practices that have provided at least two generations of partners in certain specialities, most notably geriatrics. For instance, in the mid-1960s, partners in Robert Es practice accepted part-time appointments in the local geriatric units, including the assessment unit and four long-term stay units. Robert is now retired, but David D, who currently works in the same practice, has a clinical assistant post in long-term geriatric hospital care.⁶

In the earlier years, shared social activities constituted one of the most striking forms of connection between doctors in community and hospital. As well as the local medical society and its regular golf contests, there were a number of local organisations and events, including a dance society that involved both male and female doctors, all providing opportunities for doctors to meet. Such informal networks are recalled as significant in the memories of older GPs and seem at least to have consolidated existing working relationships. There is some evidence that there has been a decline in these activities in the 1990s. According to the working GPs who were interviewed, the impact of policy change in the past decade has been significant, although it is a significance that is argued over. The ways in which fundholding, for example, has shaped the relationship between primary and secondary care is disputed.

In conclusion, the oral evidence from Paisley is at odds with the view that there was an inevitable and deepening division between hospital and community medicine in Britain in the second half of the 20th century, as Honigsbaum has argued.⁷ Of course, there were stresses and strains, particularly as regards improvement in access to various hospital-based technologies,⁸ which was as welcome in Paisley as it was to family doctors elsewhere. Nevertheless, a significant section of Paisley's GPs not only reported good relationships with their local secondary care colleagues, but were also able to provide evidence of close associations.

The oral evidence

In the early years of the NHS a number of GPs, including Patrick McC, worked in both community and hospital medicine.

Patrick McC: *'I was appointed an Honorary Surgeon to Alexandra Infirmary in 1946 at an honorarium of £100 per year. It worked out at sixpence per appendix. In 1948 the health board took over the hospital and my honorarium went up to £200 per year; an appendix at that time was a shilling. In 1950 the health board settled in their own medical staff and, not being a close member of the medical mafioso of Glasgow, I reckon my chances at 28, 29, of getting a consultant post were zilch, so I abandoned surgery for general practice only.'*⁹

Older family doctors recall that the relationship between primary and secondary care deteriorated during the early years of the NHS.

Gerard D: *'We were second-class citizens and again in those days [prior to the 1970s] it was not uncommon for GPs to be talked down to...'*¹⁰

Robert E: *'I think there were probably, some of the consultants who were appointed to begin with came from some of the big hospitals and ... possibly among some of the GPs, there was an attitude of regarding them [the consultants] as being the fount of all knowledge etc. And a certain amount of deference shown to them...'*

However, formal and informal networks began to develop, especially among the men.

Robert E: *'Paisley Medical and Pathological Society ran clinical meeting once a month when the Health Service started. And the hospital [the RAI] got more in the way of better-qualified consultants. They ran the meeting, but the GPs all went to them. It became quite a social occasion ... a discussion and a cup of tea and a blether [chat] afterwards.'*¹¹

Donald W: *'Coffee in the board room was going on in the 70s ... [laughs, pause] There weren't terribly many of us invited to that ... there was only one or two that took advantage of that. Thursday lunchtime ... it was very good, because a consultant in the hospital was brought down and he spoke to us ... So you got to meet them there. And of course I got to meet most of them on the golf course.'*¹²

Douglas H: *'In the old days when I started practice and even when I was a resident in the hospital anybody who golfed went on these outings ... That gradually changed so it was only people who played golf seriously...'*¹³

It is tradition that has continued. Graham D began to practice in the town in 1993.

'I do other things apart from just organise, it

*might not sound that way, I've got to know more of them [Paisley's doctors] socially and quite happy to refer things back and forward through organising the Paisley Medical Golf Society...'*¹⁴

GPs and hospital doctors began to get know one another, partly as a result of so many having worked together as registrars in the same hospitals.

Robert B: *'Very quickly you get a feeling for the GPs in the area — this is a good lad, you know, I can comfortably accept he'll be honest with me.'*¹⁵

Donald W: *'I liked Paisley because it was a nice circumscribed area ... You had the various hospitals that you needed within the town itself. You had all the specialist facilities of Glasgow when necessary. You know, it made a huge difference ... you had this small district hospital ... So Paisley's a good place to practice in.'*¹⁶

Those trained outside of the town and its environs have not always found it so easy and other strategies have developed.

David R: *'Coming to the West of Scotland I found that it was just easier to make friends with other outlanders.'*¹⁷

Christopher J: *'I always say to patients, "And what was the doctor like?" ... If they didn't like him, or he was really rude, or whatever, I just didn't send them any more patients. I just basically work like that ... One of the trainees here — her husband was a consultant at the Royal [in Glasgow], [a] vascular guy. So they get a proportion of our vascular patients who go to the Royal rather than the Southern or the Western just because I know him, I can write "Dear Paul" on the letters, which is always nice.'*¹⁸

Some claimed that relationships between hospital and family doctors changed when the Royal Alexandra Hospital (RAH) replaced the Infirmary.

Gerard D: *'...the RAI always seemed a much more friendly open place. Now perhaps that's my reflection of it because I was beginning to get to know it, go to meetings, occasionally go into the ward ... occasionally go to the blue room or the pink room, etc. Go up and see a consultant to talk about a patient ... and then the new hospital came along. You know, it seemed bigger, less personal, starting to get ... younger consultants that you didn't know.'*¹⁹

Linda F: *'...There's not the same friendliness. It's quite interesting; the staff who were there pre-RAH you still have the same friendly atmosphere with them. There seems to be a greater gulf between the hospital and the GP staff in certain specialties. In others there's probably closeness. If you can actually find someone at*

*the hospital that you can get to know it's not so bad.'*²¹

John H: *'You can't get parked anywhere near it. You're busier during the day so it's more difficult to find the time to go up and do these things and it's been a fair while since I've been up to visit anybody in there, a couple of years.'*²¹

Graham D: *'I've been trying to foster relations, because I think we've got to all work together a little bit more. It's been harder trying to do it with the hospital, because they still regard themselves as, "We're the hospital, we're secondary care, we don't deal with that sort of stuff." But I've been involved in the Drugs and Therapeutics Committee and ... RAH informal meetings with GPs.'*²²

Older and mid-career GPs, like Charles McC and Christopher J note the ways in which patient care has shifted.

Charles McC: *'...And it is very obvious in general practice that you have got to watch a patient who is attending a specialist unit because they can be sitting with something which is nothing to do with their speciality and nobody aware of it.'*²³

Christopher J: *'I just don't refer anyone to hospital with hypertension any more, diabetes — a large amount is dealt with here. Asthma is dealt with here. ... We do more investigations before we send people to hospital nowadays. Hospitals send people out earlier; we have more postoperative care ... Long-term care in hospital is reduced. They have emptied the psychiatric and long-term stay wards and those people, now in the community, have to be looked after.'*

There was no sense of agreement regarding the effects of fund holding at the time the interviews were carried out.

Christopher J: *'If they're [a hospital's consultants] all awful I send them to a different hospital. And that's why the commissioning is good ... up here [in Scotland however] we have responsibility without power.'*²⁴

Brian R: *'But to my mind it didn't really produce consistent patient care, because all that happened ... in this turbulence ... the other practices who weren't fundholding did get a second-class service.'*²⁵

Donald W: *'We took the first run of fundholding. Never any suggestion that [we'd take] the second run of fundholding, with contractual arrangements with the hospital for admissions and so forth. There was never any great point ... in this particular close area here.'*²⁶

**Graham Smith
Malcolm Nicolson**

viewpoint 2

Helping doctors with disabilities succeed in medicine

NEXT time that you are at a meeting as part of your NHS work, look around you to see how many doctors have an obvious disability. You won't see many walking with sticks, using a wheelchair or with a hearing or vision impairment or other physical or sensory disability. Nor are you likely to hear them talking about their physical or mental illness, but rather hide it away like a shameful secret. Although definitive data is lacking, it is clear that people with disabilities are under-represented in the medical profession.¹

The BMA working party that investigated and identified the difficulties encountered by doctors and medical students with disabilities reported numerous examples of apparent discrimination, with many disabled doctors reporting hostile or unhelpful attitudes within the profession.¹ A pilot study of primary care workers reported that colleagues often did little to help enable disabled doctors.² For example, changes had not been made to the workplace or systems in practices to help to retain GPs and others at work.

So has anything changed since then, with the implementation of the Disability Discrimination Act? Do doctors with a disability receive the support that they should legally have, let alone the support that a facilitatory work environment and employer could give them?

The recent case of Heidi Cox,³ a disabled medical student who was prevented from continuing her degree by the GMC, has highlighted both the lack of support available from within the profession's regulatory body and the fuzziness of current anti-discrimination legislation when applied to the medical profession (in this case, a student). Local, bottom up initiatives to tackle the problems faced by the disabled (whether doctors or not) are a good start such as the recent efforts in Bristol to make undergraduate medical students more aware of disability issues.⁴ But much more needs to be done at the top of the medical profession to promote equality of opportunity for disabled doctors and medical students.^{1,5,6}

The letters that pour into the *BMJ* Career Focus column show that many doctors with illnesses and disabilities feel let down and unsupported. Disability is not just the end result of either mental, physical or sensory impairments or long-term ill-health. It is about the loss or limitation of opportunities. Both disabled people who want to study medicine and doctors who have served the NHS for years before becoming disabled or ill find that there is precious little support for them. The *BMJ* Careers Chronic Illness Matching Scheme was set up to help plug this gap but this alone is not enough.⁷ There needs to be a centralised support and advice system, backed with adequate funding.

There are many inspiring and determined disabled doctors who succeed in the medical profession despite a tremendous struggle.^{8,9} However, we believe that it is unacceptable that disabled or chronically ill doctors can only continue in their chosen careers if they are superhuman. Doctors with a chronic disability or illness don't want pity or special treatment. They want a level playing field that enables them to fully contribute to their profession. Much more can and should be done to help them to succeed.

Ruth Chambers
Rhona MacDonald
Stewart Mercer

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Depressed? You must be joking!

IF the Sunday supplements and Claire Rayner *et al* are to be believed, the nation is drowning in a sea of collective misery. It's almost *de rigueur* to be off sick with depression at some time.

The reasons for this are obvious. They're called counsellors.

When my brother died of cancer in June 2000, somewhat prematurely at the age of 42, I needed counselling, obviously. Anyone who is crying at socially inconvenient moments, for whatever reason, needs a script for antidepressants and a nice long chat with an understanding person who's been trained to say 'How do you feel about that?' during any moments of silence.

The most difficult thing that bereaved people face is sheer embarrassment. Everyone you used to know crosses the road to avoid talking to you in the street, which is difficult enough in itself, but what about the people that can't avoid you, such as work colleagues? Broadly they take one of two approaches, both of which relate to the comedy actor John Cleese.

Most popular is the approach exemplified in the 'Don't mention the war' scene with the German tourist in *Fawlty Towers*. Pretend nothing has happened. Sweep it all under the carpet. Grief is a private thing and we really don't want anyone else's personal problems upsetting our own personal apple carts.

Some people favour the approach exemplified in the closing song of *Life of Brian*: 'Always look on the bright side of life!'. He wouldn't want you to be unhappy would he?, and the like.

When my father died in 1985 it was generally assumed that I'd get on with things and cope with it in my own way. Most people's sympathy was given to Mum as the grieving widow. There was no mention of counselling.

In the fifteen years that elapsed between those two men's deaths, the number of counsellors has grown at a rate matched only by the Duchess of York's clothing bill. This creates a self-fulfilling prophecy. The very fact that counsellors exist means that people perceive talking about it as a professional role, rather than something you do with a friend over a pint or a packet of chocolate Hob Nobs.

I don't doubt for one moment that counselling is going to remain the focus of treatment for many genuine illnesses eating disorders in particular, where the passage of time isn't going to heal and the underlying causes are often complex. Equally, victims of rape or sexual abuse need specialist help, simply because this

isn't a universal experience, but grief is something which we all have to face at sometime in our life and, ultimately, have to learn to live with.

Bereavement is a long and painful process. It's as much part of life as night is part of day. It's something that we're all going to have to face at some time in our lives. It's a sad reflection on the state of our increasingly fragmented society that most people see grief as an illness which requires the help of a GP and a counsellor.

How many of the people who turn up in your surgery are there because some well-meaning person has sent them there? Bereaved people turn to their GPs out of desperation, not as a first port of call. But this process is part of the problem, not part of the solution, as bereavement counsellors turn grief into an industry.

Labelling a bereaved person as depressed and sending them off to see a counsellor is, arguably, the worst thing that a doctor can do. This just completes the circle of society's expectations. A better option would be to get a puppy, or grow your own vegetables, or do evening classes in conversational French.

Counselling can never be an answer to grief. Talking endlessly about the deceased person and how much you miss them will never make a difference. Ultimately you learn to remember them, smile at the good times, regret the rows, but above all you learn to move on. Eventually you might even forgive the people who crossed the road to avoid you. This isn't something that a doctor, however well intended, can help with.

Fiona Dowson

The heart's delight — (Memories of an operation in 2001)

IN August 2001, I was admitted to the cardiac unit of the main hospital in Murcia, Spain. I was to have a heart valve replaced and a narrowed coronary artery bypassed. My attitude was essentially, 'Let's get it over with.'

What follows was written a few weeks after my return home.

I was an Irish joke. The operation was a great success but the patient died. I was dead for six weeks, which is 42 days; or, if you are counting, 1008 hours. Rip Van Winkle, poor Lazarus, the Sleeping Beauty. Did you see anything of the, eh, other side? asked my friendly neighbour afterwards.

Hortensia switches on the tape and plugs in the earpiece, into my incoherent head. Sweet-soaring alto sax of Gay McIntyre, from a major to a minor, to a seventh, resolving back to the major, and I open my

eyes, an improvised act on a major chord. And he lives in Derry!

Outside my window, a soaring builder's crane, T-shaped jib, a red warning light for an eye, a high hawk watching over me. The red eye blinks all night, a warning to low flyers and high spirits.

I, octopus-tentacled with tubes in my nose to feed me, in my mouth for air, in my lungs for drainage (in my penis for fun?). The sack of bright red blood gently swings and drip-drops into my arm. That's life.

White figures glide to my bed. Someone's pressed the mute button: Just taking your temperature. Don't bother, I'd say it's 36. Blood pressure? Don't bother, it's 140/80. By God, he's right. How do you know these things? Where I live I know everything.

Hours later they return. I, sick from every orifice, violently strong nurses with basins of water, sponges, and sweet-smelling soaps. Yesterday they smelled of almonds, today liquorice. I suppose it takes all sorts.

I sleep again. Now a brown bull charging into the plaza. I turn fast, as we bulls do, to face them and they are all there, in a semi-circle, swords raised.

My, you're definitely looking brighter today.

You'll be out of here in no time. What a difference, you look great.

My silent shouts vanish into white walls, and the blonde rinses turn back to recipes, food, and those little imperfections of the skin that are so troublesome.

Back to night-night, have a good rest, and my metal bird winks in conspiracy; in the long silences a dog barks: a country dog, confident at home on his own ground. A motorbike roars away into the night. Home to warm beds and deep comforts. Soft cords secure to the bed... Trick! Trap! Traitors! I twist in hell. The needle slides in, and sleep slides out on the wings of my big bird.

Daylight. Another day. I am sick again; washed, changed, tubes checked, readings read, bloods taken. Do I see a smile? Tomorrow you're going home.

We pass down long corridors, swoop down in lifts, and suddenly in my wheelchair I am outside the automatic doors. September sun touches my face. Will it always be like this?

Adios, says the wheelchair nurse, and I am alone, high and dry, and on an airless day the slap of a late wave at the end of Ballycastle strand. The tide of reality washes over me, and life rushes back into September.

Samuel Fannin

Virtue ethics cannot be the answer!

A reply to Peter Toon

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IN the third and fourth essays in the *BJGP*'s recent ethical quartet^{1,2} Peter Toon claims that the adoption of enlightenment philosophy and Beauchamp-and-Childress-style principlism into medical education has somehow failed to prevent the Bristol and Alder Hey tragedies. Furthermore, he explicitly rejects deontological and utilitarian theories and rules as being helpful for doctors in deciding how to act in a given situation. He asserts that character, not reason or duty lies at the heart of moral life, and that all we need to do to be good doctors is develop good character traits, or virtues, and we'll just act rightly as naturally as breathing.¹

In this article I will provide an argument as to why this is not the case. I will argue that virtue ethics is inadequate as an ethical framework for medicine, and cannot be independent of notions of rules, values, and duties inherent in post-enlightenment ethics. I will then go on to discuss how post enlightenment ethics might be applied to general practice and what some of the implications might be.

So what are the problems with virtue ethics. Why can it not enable us to act rightly?

Firstly, most of us would agree that accurate self-analysis with regard to our virtues and vices is notoriously difficult, if not impossible.³ Acting on the basis of such self-reflection may be inappropriate and potentially dangerous if we haven't got it right!

Secondly, it is difficult to accept that being virtuous alone will cause us to act rightly, especially if we agree that rules should be eliminated from all notions of virtue (eliminativism). If, for example, we accept that courage is a virtuous character trait, independent of ideal principles,² then the courageous doctor is equally morally laudable whether the use of the courage is appropriate in, say, approaching a violent or disturbed patient to offer medical help, or inappropriate in, say, carrying out heroic surgery on children without adequate skills to do so. We all recognise that this cannot be so. An eliminativist accepts the character trait of facing fear (courage) as morally good, regardless of the consequences or any other considerations. This kind of virtue ethics cannot therefore provide us with a useful analysis of a medical tragedy, such as Bristol or Alder Hey, where the consequences were of prime importance. Mulling over the virtues and vices of the doctors involved somehow seems an

inadequate response to what happened.

For virtue ethics to provide us with any useful tools for analysing medical practice, we must agree that there is a core set of rules or values, which establish whether character traits are good or bad (essentialism). These rules or values will tell us why virtues, such as courage, are different from character traits, such as a tendency to sing in the shower.³ This, however, brings in notions of rules and duties that have a distinctly post-enlightenment rationalist flavour! Toon himself suggests what some of these rules or values might be in his example of the young couple with the baby with Down's syndrome.² The doctor strongly offers the possibility of adoption, in the face of the father's rejection of his newborn, and the offer is accepted. The couple go on to have three brilliant sons with successful professional careers.

It is easy to agree with Toon that it was courageous of the doctor to act in this manner. However, Toon goes on to wonder whether the doctor's actions would have been considered foolhardy if things had gone horribly wrong.² He appears to suggest one cannot agree that simply being courageous was enough to act rightly, when he says that the nature of practical wisdom requires an imaginative capacity to predict accurately the likely consequences of different courses of action.² This is clearly post-enlightenment utilitarian thinking. When Toon suggests weighing up the good and bad consequences in the situation and making a decision to maximise the overall good in such a classical utilitarian manner, he demonstrates that virtue ethics as applied to medicine cannot be independent of the post-enlightenment rules and values he rejects.

A deontologist would, as Toon rightly suggests, be critical of the doctor's behaviour in this scenario. Feminist ethicists even more so! The doctor has imposed his own values on the couple and made his own judgement about what constitutes a good outcome in this situation. We might question the assumption that the marital relationship is worth preserving, or why it should take precedence over the mother child relationship, or the power imbalance between the genders and the coercive effects it could have in this situation. For the deontologist at least, the values of the patients are what is important here, and the doctor's duty is to preserve and enhance the autonomy of the individuals involved. In practice, this probably translates into non-

directive counselling, empathic listening, offering unconditional support, and empowering the individuals involved to make the decisions and take the actions that they judge are right for them.

Returning to Bristol and Alder Hey, we might agree that the doctors were courageous if we are eliminativist virtue ethicists, or foolhardy if we are essentialist virtue ethicists. As a utilitarian or deontologist we would simply say they were wrong, because they failed to maximise the good, or they broke the rules. Only post-enlightenment ethics can provide an adequate theoretical framework to address cases such as these. It is precisely the widespread adoption of bioethics and post-enlightenment philosophical thinking in general about the ethics of medicine, that have enabled us to recognise what was wrong at Bristol and Alder Hey and why such events cannot be accommodated by notions of professional privilege and clinical freedom. Virtue ethics can never provide sufficient condemnation of such cases and thereby runs the risk of being viewed by the public as a tool for professional protectionism, and fudging of major problems in medicine and medical regulation.

In medical education, then, the teaching of post-enlightenment philosophical skills is vital. The aim of teaching is not to provide a list of rules to act by (and it is debatable whether any of the doctors involved in the Bristol and Alder Hey tragedies had ever had any training in bioethics) but to challenge students to develop new ways of thinking about themselves and their patients. Teaching also aims to provide flexible tools for understanding the student's own views and other people's thinking and values. For students with no views on a particular topic, it can help them to develop some rationally coherent ones. For students with strong religious views, discussion of enlightenment philosophy can help them to understand how western secular views have developed. The teaching promotes tolerance and understanding, rather than a set of views about what's right or wrong.

So what of post-enlightenment ethics in general practice? So far it has barely begun to be applied. The few who have tried have thrown up uncomfortable challenges to activities we routinely perceive as good practice, such as cervical screening,⁴ coronary heart disease prevention,⁵ and following guidelines.⁶ There are huge implications if, for example, we accept that

the duty to respect the autonomy of our patients means we must obtain informed consent from them prior to any examination, treatment or investigation, as the GMC suggests.⁷

First, genuinely informed choice about whether to undergo interventions, such as cervical screening, blood pressure or lipid profile testing, may be difficult in practice, owing to insufficient evidence of benefit or risk to the individual patient.^{5,8} This raises the question of whether we can obtain informed consent to these interventions at all, and therefore whether they are ethical (something a utilitarian and a deontologist might disagree about).

Secondly, patients agreeing to an initial test are often seen as inherently agreeing to further investigation or treatment if the tests show high risk.⁹ This is often because of health professionals' belief in the value of early diagnosis (which may not be based on research evidence)¹⁰ and because of the power differential in the doctor-patient relationship. Patients often find it difficult to refuse further intervention, or even to understand that they can.⁹ This raises questions as to whether patients are participating voluntarily and therefore whether testing is ethical.^{4,5}

If we are to enhance the autonomy of patients and obtain their informed consent in primary care, then we need to review practices, such as checking blood pressure opportunistically simply because the patient is there and hasn't had it done for a while. GPs and practice nurses need to have a full discussion with each patient of what the purpose of the blood pressure test is and what the likely risks, benefits, and outcomes might be before they start. This could have a significant impact on consultation length and practice workload.

Rogers, in discussing the moral problems with clinical guidelines, suggests that we need to clarify the moral basis upon which priority setting and resource allocation decisions should occur.⁶ As GPs, we need to clarify the moral basis upon which our day-to-day practice rests. I suggest that Peter Toon would probably agree with this statement. However, if we are serious about doing the right thing for our patients and improving both the quality of patient care, and the public's confidence in the medical profession as a whole, we need to use our post-enlightenment philosophical thinking hats more, not less!

Diane Reeves

The Lundbeck Award for Best Practice in Depression

The Lundbeck Award is a new UK health award to reward excellence in depression among practice teams and is jointly organised with the Depression Alliance, the national charity for depression.

The award attracted over 50 well-prepared applications for the £10 000 winner's prize. Four practice teams from around the UK were shortlisted and each practice won £3000 to spend on a mental health initiative. The UK winner received a total of £10 000. This year's award was won by Northampton's Leicester Terrace Health Care Centre.

The practice has developed a number of protocols and guidelines for the management of depression and has established itself as a beacon practice for integrated working between doctors and nurses. Clinical audit has demonstrated that professional education alone was not having a significant effect on improving patient outcome.

The practice has successfully gained continuous funding from the PCT for a new post of Primary Care Mental Health Nurse, to provide dedicated time to assess, follow-up, and support patients with depression. The practice also demonstrated a commitment to de-stigmatise depression, to ensure patients are provided with the information they need to empower themselves to make decisions about their care and treatment.

Leicester Terrace Practice hope to use the £10 000 to help share best practice and to become a multi-professional teaching practice, particularly around the role of the primary care mental health nurse, providing training for members of local primary health care teams. It also intends to use the money to help fund a professional training centre.

The resourceful patient**JA Muir Gray**

Rosetta Press, 2002

PB, 154pp, £14.50, 1 90420200 4

ONE of the most disturbing aspects of being consulted by a medical colleague is the need to appear as knowledgeable as the patient and certainly not ignorant. This experience is now increasingly extending to non-professionals, those who have informed themselves, the few resourceful patients. Part of the assertion of power dynamics in the consultation is the exercise of knowledge based on a supposed or real acquaintanceship with facts, and increasingly the power of knowledge will be a valued shared by two equal participants: the doctor and the empowered patient.

We have all heard tell of doctors discomfiture when someone first consulted with a printout from the Internet. My Internet information loss of virginity was with a man who came querying whether he had Lyme disease. Having established that he had recently been bitten when visiting the east coast of America, I then took less than 15 seconds to exhaust my entire recalled knowledge of Lyme disease. Seeing this, the patient helpfully produced all the information I might require, printed from the American Lyme Disease Foundation website (<http://www.aldf.com/>) including an enlarged picture of the tick. Between us we figured out how to investigate the possibility of this diagnosis.

In the future, many patients will come to consultations as well-informed experts in their health. They will know as much, if not more, about their diagnoses, drugs, treatment options, and prognosis as their doctors, and they will know far more about their specific health their previous illnesses, their response to drugs, their preferences for management all recorded in a patient-held record.

It is these resourceful patients that this wonderful book addresses. It echoes the changing relationship between doctors and

their patients, with the doctor evolving from the deity believer relationship of previous centuries, through the expert supplicant relationship of the 20 century, into the adviser decider relationship of modern medicine.

While some will never wish to be empowered to take control of their own health, we know in diabetes, for example, that programmes such as DAFNE (Dose Adjustment for Normal Eating), which give insulin dosing control to the person with diabetes, result in a significant drop in glycosylated haemoglobin.

To achieve this, especially in the areas of primary and secondary prevention, doctors must be able to express risk in a way that lay people can understand and use in rational decision making. For me, the section of this book on interpreting and expressing risk is the most effective I have encountered.

Muir Gray is known to many from his roles in public health, screening policy, and leadership in the Electronic Library for Health especially in the Oxford region. However, his greatest strength is in the leadership of innovation and ideas. This book distills all his knowledge and experience into a highly readable form and, in its production, illustrates his understanding of the modern environment. The first printing of this book took three days from completion of the text in the word processor to book in hand; the second printing reduced this process to under 24 hours. Not only has Muir bucked the publishing cycle, but also, of course, you can savour it online without recourse to a physical book. Just go to www.resourcefupatient.org and a world of information, ideas and challenge will open up to you.

Mike Pringle

A Long Walk Home

Rachel Clark (with Naomi Jeffries, John Hasler and David Pendleton)
Radcliffe Medical Press, 2002
PB, 148pp, £19.95, 1 85775906 0

THIS is a book about dying. Rachel Clark died of cancer aged 28 a girl with life just opening out. It's a pathography which spells out important messages for patients and the health professionals who look after them in essence, about the communication and relationships between these groups of people. She has an ability to recount her poignant observations, sometimes with humour and always with a view to providing learning opportunities for health professionals.

Listening to patients and understanding their experience is vital for any health professional. Sadly, this book teaches, among other things, what not to do, how not to be. Rachel wanted to explain to people what the treatment actually involves. How cancer affects your life. How you feel. She succeeds; it's not a jolly read.

There are four parts: the illness story; a summary of the wealth of research material, making it equally available to health professionals, cancer patients, and their relatives; a commentary by a GP and a psychologist; and the brief tragic account of Rachel's last days by her twin sister.

Had Rachel not run out of time, the text would have been more coherent and gripping if the first two sections were amalgamated. The third section, by Hasler and Pendleton, though clear and useful, communicates far less readily. They speak of the patient, and formulating management plans.

Rachel's story is vividly and undidactically written. We learn most readily from storytelling, from an author speaking in a human voice to their reader. And the story is the most listenable form: where human communication started.

Rachel's story will be invaluable in teaching. What Rachel would have wished most dearly is that her story be listened to and acted upon.

Gillie Bolton

Mental Health Primary Care in Prison

WHO Collaborating Centre for Mental Health Research and Training
Edited by Jo Paton and Rachel Jenkins
Royal Society of Medicine Press, June 2002
PB, 379pp, £24.95, 1 85315523 3

THE introduction to this book states quite clearly that prisoners are the most vulnerable individuals in society. This must surely be one of the greatest understatements ever written. One cannot think of any other institution that collects the most deprived, most disadvantaged, least educated, most abused, most addicted, sickest, heaviest smokers and drinkers and the most mentally unhealthy individuals and place them under one roof, and then leave their care to the least trained and the most unsupported doctors, without access to IT and precious little support or protected learning time. Then add to this a turnover rate of patients approaching 80%, where all the patients arrive at the same time usually 7.00 pm in the evening, where all your mistakes as a doctor are magnified and invariably played out in disciplinary committees and where your ability to provide evidence-based care is thwarted by financial constraints or historical prejudices. This is what prison general practice means and I take my hat off to all those doctors who currently work within these institutions. They need our admiration and certainly our help to address the problems they face in trying to provide humane care.

This book will help, somewhat. It's not a bedtime read, it's really a textbook on best practice, with information easily presented and well laid out. The book is a larger version of the *WHO Guide to Mental Health in Primary Care*, adapted for use in a prison and young offenders settings. It's a mighty tome yet still in a pocket book format. The book is packed with useful and practical information for prison doctors, such as how to defuse aggression, deal with an overdose of batteries or understand the meaning of a dirty protest. The book aims to be a practical guide, with chapters laid out into five main sections, from basic information on diagnosis and treatment through to important related matters, such as legal and ethical issues and working with the voluntary sector.

My criticism, if anything, is that in parts it is a little naive and simplistic. For example, in

the management of insomnia, the book encourages the doctor to consider lifestyle, the prisoner may spend most of the day asleep in his/her cell. Well, what else is there to do if you are confined to your cell 23 out of 24 hours take up paragliding? Or if the patient snores loudly with permission take a history from a cell mate. Perhaps better still, remove the snoring cell mate who's keeping the patient awake all night, or maybe give some practical advice to the prisoner on how to make and fit ear plugs or dissociate themselves with self-hypnosis would be better.

The eating chapter, again, I think naively presents the problem and the solution. I am not an expert in this area, but often, as with children, feeding issues are used as a weapon refusing to eat being the only action a prisoner may have control over. How does the prison doctor deal with this? Certainly not counselling, even if it were available.

Can I recommend this book? Certainly for prison doctors it will be an invaluable resource, but general practitioners should dip into it, if only to make us realise that, no matter how hard we think we work, how difficult the constraints are, they will never approach the problems faced by our prison doctor colleagues.

Perhaps the real value of this book is as a guide to best practice and as a means of lobbying the governor for the resources to treat patients as such. If it's what the World Health Organisation, the Royal Colleges of Psychiatrists, General Practitioners, and Nursing, the Faculty of Public Health Medicine, King's College Hospital, and the Institute of Psychiatrists all say this is the best way to manage prisoners, then surely others cannot argue.

Maybe in the future prison doctors will have the technology to use the diskette included with the book at least before they become extinct anyway.

Clare Gerada



paul freeling *an appreciation*

FOLLOWING a prolonged illness borne with great stoicism, Paul Freeling died on Friday, 13 September 2002. He was 74 years old. He is survived by his wife Shirley, who supported him heroically during his illness, his son Anthony, and daughter Nicola.

Paul was Emeritus Professor of General Practice at St George's Hospital Medical School, where he had also been Vice-Principal.

In 1952, Paul qualified from St Mary's Hospital Medical School and later entered general practice in Southall. There he was much influenced by one of the partners Max Clyne, a leading member of the Balint 'old guard'. In 1960, Paul himself joined a group at the Tavistock, where he met and collaborated with Kevin Browne. They co-authored a series of articles for *The Practitioner* under the title *The Doctor Patient Relationship*. Published in book form in 1967, it went to three editions; the last, in 1983, substantially revised with Conrad Harris as co-author. These collected essays introduced a fresh language to encompass what had often seemed beyond description in the relationship between doctor and patient.

In 1972, Paul became internationally known as one of the six authors of *The Future General Practitioner*. All four of his surviving co-authors were present at his funeral to bid him farewell. The reputation of his highly distinctive style of teaching dates from this time. Paul threw away the rule book on small group facilitation. To take part in one of his training seminars was to enter a bull ring. He would soon let you know whether and when you were to be one of the banderilleros, and when the bull. Paul was always the matador.

Similarly, those of us who spent years on College Council with him remember the quiet thunder of his contribution to debates – the originality of his approach puzzlingly illustrated with rabbinical parables, no less telling for the fact that we none of us ever precisely got the point of the stories that he told.

It was Donald Irvine who in 1973 had the courage to nominate Paul to direct the Nuffield project. He was to prove a stunning success in that role. For three years, Paul conducted intensive residential workshops for the then recently appointed Regional Advisors. These Nuffield alumni were to transform the culture and training of future doctors, and the *imprimatur* of Paul's personality and style on that culture and training was, and remains, indelible.

The list of his publications, academic offices and visiting professorships is as distinguished as it is long. He made important contributions to research on asthma and depression, combining quantitative and qualitative methods. There have been many honours. In 1978 he gave the William Pickles Lecture. In 1981 he was created OBE. In 1992 he was awarded the College's Foundation Council Award, and this year the President's Gold Medal.

I first met Paul at school where he was already a leader and my head of house. We met up again in 1966, as members of the same College Faculty Board. We were to work together, often to squabble fiercely over some idea or other, like a couple of pigeons disputing a solitary bread crumb, and always to laugh together, for the rest of our professional lives. He was not always the easiest of men. Many years ago Paul advised his young daughter: 'You can be the sort of person that nobody will ever dislike, and nobody will ever remember. Or you can be the sort of person that some will certainly dislike, but whom others will love'. He could have been writing his own epitaph.

Paul was a giant of a man; he had great warmth, an unusual intellect, moral purpose, wisdom, and generosity of spirit. We were privileged to have known him. Those of us who loved him will remember and miss him.

Marshall Marinker

IF the latest crisis in the NHS has left you reaching for your resignation letter, then a dose of laughter medicine from Dr Phil Hammond, of BBC Radio 4's *Struck off and die* and *Private Eye*, might be just what the doctor ordered.

Phil is a GP and he works in genitourinary medicine in Bristol – an occupation which provides him with prime comedy fodder. The show kicks off with the story of a gentleman who tried unsuccessfully to self-medicate his genital warts with a cheese grater!

The show dissects the potential saviours of the NHS, exposing each of the candidates' failings with skilful satiric wit. He rips through the medical profession's thin veneer of respectability to reveal a sordid underbelly of mishaps and misdemeanours. Phil illustrates these points using his own back catalogue of near misses, with a frankness that would not be out of place in a confessional.

Patients do not get off the hook. He tells them to take responsibility and question their doctors. To illustrate this point he told a story from his book, *Trust me, I'm a doctor*, in which a female patient told a misconduct committee that the doctor started kissing her tummy, but it wasn't until he started to examine her breasts with his mouth that she became suspicious!

And Phil's answer to who can save the NHS? Patients of course! If you feel well, don't bother your doctor, but if you discover a large lump growing out of your neck go to your GP. A reasonable message to a low risk, Edinburgh festival fringe audience. Advice perhaps less appropriate for my Glasgow patients, who will die on average 10 years earlier than their Edinburgh compatriots.

Phil may not have all the answers to the problems of the NHS, but a large dose of laughter therapy will keep the blood pressure down and the breakdown away for a little longer. If you are too busy to go yourself, send your patients. They may look at you in a new light but it will be worth it if they become more responsible consumers of the NHS.

Joan Scott

Dr Phil Hammond is touring the country throughout October and November. For tour dates go to www.karushi.com/comics/phtour.htm

roger neighbour *behind the lines*

On consultation skills

WHEN I were a spotty lad and I still have my 1963 bottle of crumbling tetracycline labelled *The Tablets* to prove it – the general practice consultation was an altogether brisker and more straightforward affair. Make (or pretend to make) a diagnosis, prescribe or refer, ring the bell for the next patient. Sorted. (Ironic to think that then, when GPs had time for longer consultations, they didn't bother, whereas now, when we don't, we must.)

Readers of these pages will know that I'm not above a little hypocrisy, as long as it's honest. So I confess to sometimes wondering whether we aren't in danger of elevating the consultation process to something rather more sophisticated than is good for it. As well as (and sometimes instead of) just being how someone's health problem gets fixed, the consultation has become a rollercoaster ride through a giddy terrain of extra tasks, goals, and processes of which the patient is usually unaware. It's when we doctors get out our consultation models. It's our chance to dress up as an advocate or a freedom fighter, and see if we can get our heads round words like autonomy, empowerment, narrative and transference. It's when we play games like hit the target, and pass the protocol and hunt the hidden agenda.

It's actually not the consultation that's got complicated: despite all the flim-flam it still comes down to do as you would be done by. But golly! haven't we made an obstacle course out of learning how to do it. Books, models, checklists, courses, videos, role-plays. All this to try and make young doctors look experienced, and experienced ones behave as if they were students again. But luckily, if we let them, the patients remain our ever-present and most effective teachers. Two case studies follow, both cross-my-heart true.

Henry, aged 62, has a swollen testicle. As he tells me about it, I know he thinks – and I think he knows I know he thinks – it's cancer. But the history's not right: and, when he's up on the couch, it looks to me like an epididymo-orchitis. Phew. Well, probably phew. Time to manage uncertainty, remember safety-netting. I'm pretty sure it's just an infection. I begin: a urine sample prescribe a course of see you in a week.

Phew, he's thinking, and his confidence starts to return. How've I got that then? he asks. Damn. I reach into that cupboard in my mind where I keep the flannel. As we get older the bladder – the prostate – Henry knows I'm bluffing. Can you get it from sex?

I'm well onto the back foot by now, and couldn't spot a minimal cue if it bit me on the knee.

Cos if so, he continues, it must have a bloody long incubation period.

Giles, aged eight, has a skin tag on the side of his nose, and his mother says he wants it removed. Hmm, I think patient-centredly, painful place to put some local in; and I say as much. Oh, says his mum, expressing her Ideas-Concerns-and-Expectations as to the manner born, I thought you'd just tie a bit of cotton round it. Okay, says I, grateful for the chance to Incorporate Her Health Beliefs. So Giles climbs up on the couch while I prepare a loose knot of black Sylko and advance on my target. Ethical dilemma: shall I tell him it will hurt for a moment? If I do, he'll flinch and I'll miss with the noose and it'll all – So I think stuff informed consent and just do it. I lasso the skin tag, give a quick yank, and snip off the loose ends. Sorted.

Well, Giles is eight, which is nearly grown up, so although I've brought tears to his eyes he manages not to yelp. And they both get up to leave. Come back, says his mother, what do you say to the doctor? And Giles, aged eight, his hand already on the door handle, looks me in the eye and says in a shaky treble, You bastard.

Maybe some complexities are best left undeconstructed, some pretty jigsaws left intact and not pulled apart into pieces for clumsy fingers to fiddle with. Best just enjoyed. I reckon we need fewer educational paradigms, and more teachers like Giles and Henry.

Annual General Meeting

The Annual General Meeting this year will be held at the **Victoria Park Plaza Hotel on Friday 15 November 2002, commencing at 2.00 pm**. Normally, the Notice for the AGM is included with the October issue of the Journal. This year however, because there are a substantial number of pages due to the proposals relating to the updated College constitution, the Notice will be posted out to all members of the College separately. The meeting will include as usual the presentation of Fellowship and Awards, a lecture by Professor Mike Pringle entitled *A Dog's Life*, as well as formal College business. In addition to approving the new constitutional documents, the formal business will include a small change to the bye-laws

Budgets 2002–3 and 2003–4

Council formally approved the audited accounts of the College for the year ending March 2002, which resulted in a surplus. Council also considered the most effective way of deploying the resources and approved the allocations set out in the paper circulated to Council.

Education and training issues

Council received a final report from the Examination Policy Development Group (EPDG), chaired by Dr Has Joshi. The group was formed to consider the issue of the potential for wider choice in the MRCGP examination. This related to the motion to Council from the North East London Faculty on the use of simulated surgery. A formal response to the Faculty will be made.

The Group's remit had broadened to look at the wider implications of development work on the examination. The report noted that a response was made to the last Council meeting, spelling out the difficulties in widening the choice in the examination, and this was accepted. Considerable work has been done on developing a new draft syllabus. This had been the subject of a wide consultation and received a very favourable response. It is planned that a final draft will come to CEC in October and then to Council at its meeting later this month.

We will now be setting up a new group, under the chairmanship of Has Joshi, with a wider representation than the original EPDG, which will take on the outstanding issues identified by the old group. There was also a discussion at Council about two other important documents that have just been published by the Department of Health, which will have an important impact on the development of the College examination and the whole area of vocational training. These are the *Policy statement on the Postgraduate Medical Education and Training Board* (PMETB) and the recent consultation launched by the Chief Medical Officer for England, entitled *Unfinished business: proposals for the reform of the Senior House Officer grade*.

The Senior House Officer review will be the subject of a wide consultation. Responses from members of Council are very welcome, as are comments from the Faculties. There will be an opportunity for Council to consider and approve the final draft of the response this month.

Updating the constitution

Council had the opportunity to discuss the drafts of the new constitutional documents. There was an extensive consultation earlier this year, following which Council agreed that a number of substantive changes would be made to the College constitution.

Following a few minor amendments, Council approved the draft documents to be put to the Annual General Meeting this month.

GPs with special interests

As reported in my last Council letter, the College has prepared a bid to the Department of Health to develop frameworks for clinical areas for GPs with special interests. Following a recent meeting with the Department, the College will be funded for the development of ten frameworks. This paper was e-mailed to all members of Council and Faculties before the meeting with an invitation to members to express an interest in taking on the role. Unfortunately, due to the short timescales, a more thorough process to identify a lead for this project was not possible. The announcement of the name of the successful candidate will be made shortly.

New Century, New Challenges

There was strong support for this document, which had been prepared by the heads of departments of general practice and primary care in the medical schools of the United Kingdom. The report highlights the progress that has been made since the publication of the Mackenzie Report in 1986, but also illustrates some of the major problems and challenges for the future. As Professor Graham Watt's commentary on the report states, the most urgent issue is the need to articulate and communicate a vision of the future of general practice and primary care in which academic activities play a larger part. The report calls on key decision makers in academic medicine and the NHS to support further development of academic general practice and primary care in the UK, as a key element for medical education, primary care research, workforce development, and better patient care. The report was subsequently launched during National General Practice Week.

Professor Amanda Howe and Professor Steve Field, who chair the Research Group and Education Networks, respectively, will be considering how the College can use the report and disseminate it more widely.

General practice as a specialist discipline

At the March meeting of Council there was a discussion on the current position of the College regarding using Title III and Title IV of EU Directive 93/16/EEC for GP training in the UK. A paper from the College's UK delegation to European Union of General Practitioners (UEMO) was considered. The paper sought a mandate for UEMO to pursue the recognition of general practice as a specialty. The resolution gained strong support from Council.

Framework for Involvement

Information was given about the Framework

for Involvement that has been drawn up by the Chairman. You may recall that the immediate past Chairman, Professor Mike Pringle, developed Rules of Engagement, at the time the College was being asked to respond to the NHS Plan for England.

Professor David Haslam has revised this guidance and it has now been recast in a wider context. The Framework gives advice to the Officers of Council and the various College spokespersons across the UK representing the College, or to those who are asked to give oral evidence, such as at public inquiries. The Framework can be found on the College website, at www.rcgp.org.uk

Child protection: a draft position paper

Following the inquiries into the deaths of Victoria Climbiø and Lauren Wright, and the Kennedy Report, a draft College position paper has been developed looking at the primary care role of child protection. The draft generated much discussion and many helpful comments were made. Further work needs to be done to ensure that it reflects differing child protection legislation in the four countries of the UK. Professor Yvonne Carter and Dr Michael Bannon, who have developed the paper, have revised the document, which was submitted for approval to the Council Executive Committee meeting in October.

Members' Reference Book

In order to improve communication with members of the College, we have been reviewing the Members Reference Book. Council considered the proposal to replace it with a quarterly magazine for the membership and to produce a shorter, separate Annual Report. Council supported the move to a quarterly magazine format, which was seen as a useful communication tool with the membership and would hopefully stimulate member interest. The first issue is planned for March 2003. The new look Annual Report was introduced this month.

An advertisement has appeared in the *British Medical Journal* seeking expressions of interest in the post of RCGP Honorary Editor for the quarterly members publication. This position will be open to all members of the College.

Next meeting of Council

Council will meet the day after the AGM on Saturday 16 November 2002, commencing at 9.00 am, at Princes Gate.

If you would like any further information on the matters discussed above or any other issues we have covered at Council then please do not hesitate to contact me by e-mail via honsec@rcgp.org.uk

Maureen Baker

Realpolitik

MEDICAL journals usually stick to medicine. Medicine is broad. It allows journals to make sociological comments, or to bring legitimacy to the discussion of all sorts of news stories, because so many events have medical consequences. Neither civil wars in Africa nor the continuing murderous impasse in the Middle East, for example, would normally be the subject of an editorial in a mainstream medical journal published in a stable democracy. The slant of AIDS, or the difficulties of providing public health when all around is being bulldozed, allows editors sometimes to stray beyond medical matters and make more overtly political comment. The comment is usually in response to events: disasters befall and editors want to step outside their usual boundaries. The best recent example is 9/11, although most of the editorial comment has stayed largely within medical confines, especially by articles, singly or as series, about biological warfare.

Much less commonly do journals comment on *realpolitik*. I'm not sure I can express this quite as I want to. But having chosen the word *realpolitik*, I don't want to be accused of using a word for effect rather than for its precise meaning. Realpolitik (which MS Word's spellchecker doesn't recognise) means politics based on practical rather than moral or ideological considerations, and I think that is precisely what I mean.

Because nothing has yet happened; there is not yet any event to respond to. All that has happened is a statement of intent, highly covered by the general media, but not (yet) a subject for medical concern. I don't mean what might happen to or in Iraq, although if Desert Storm 2 is launched there will be plenty of medical to write about. (The CIA have produced a report suggesting that Saddam is unlikely to use biological weapons but almost certainly will if attacked. Bright lads, the CIA.) I mean the extraordinary statements coming from Bush, and Rumsfeld, and other US hawks, that the USA won't wait to be attacked, won't even wait for proper evidence that the USA is under threat, but intends to ensure that no-one will ever get into a position to be able to attack it. They reserve the right to police the world pre-emptively, and to bend any country to their will, militarily and economically. They explicitly intend the world to be the US empire. I don't suppose they see the irony that it was from the breaking of such authority that their country emerged. But surely they see the danger of legitimising the pre-emptive strike? If not, then none of us need worry about our pensions.

Nev.W.Goodman@bris.ac.uk

Gillie Bolton wrote *The Therapeutic Potential of Creative Writing* (Jessica Kingsley) and moves soon from Sheffield to the fleshpots of King's College, London.

Ruth Chambers chairs the RCGP publications division. Her published output is prodigious. r.chambers@staffs.ac.uk

Fiona Dowson has been a Marie Curie nurse. At present she works part-time for a high street chemist and hopes to initiate some health education displays leofric@clara.co.uk

Clare Gerada started out as a psychiatrist but has now been a GP for 15 years, in London. c.gerada@btinternet.com

Sam Fannin's daughter is a GP in Ballymoney, Northern Ireland

Neville Goodman has done his back in. Obviously he needs to massage his temples and drink some fresh urine immediately

Helen Lester is senior lecturer in primary care at Birmingham H.E.Lester@bham.ac.uk

Marshall Marinker is a dashing iconoclast with elegant boots

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Ann McPherson has been a GP in Oxford for 27 years. She is medical director of DIPEX (www.dipex.org). Her latest book, co-authored with Aidan Macfarlane is *R U A Teenage Health Freak?* (Oxford University Press), a smutty book for teenagers. A more serious tome, *Healthcare of Young People: promotion in primary care*, was published in October 2002

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Reading and writing but no 'rithmetic

WHICH is the more apt: I write therefore I read, or, I read therefore I write? The two statements are so entwined that it is difficult to prise them apart and for me to decide. However, the pain of writing is far, far greater than the act of reading, which is usually a pleasure unless it involves a set book or a Department of Health strategy document. I think it was Michael O'Donnell who said that the only thing worse than writing is not writing. But I would have to disagree; it would be worse not to be able to read.

I have some friends, slightly younger than myself I admit, who never open any book except the telephone directory. I have renamed their bookshelves videoshelves. Other, much older acquaintances, think fiction is rubbish, preferring to pick out true stories, mainly about wars or science. But at least they enjoy the written word.

I should not criticise, though I do feel pity. How tragic to miss the chance to enter into someone else's imagination, to meet characters from an oblique angle to those in real life, to visit new worlds (okay – must stop before I boldly split that famous infinitive).

When I was four my mother was invited to the primary school that would soon have the pleasure of my company for seven years. She was advised not to teach me to read before starting Infants One, as it would interfere with the official method of instruction and somehow, it was implied, corrupt the communal learning process. Too late. Reading had already crept up on me, despite my elders' protestations. I remember sitting on my granny's knee while she read aloud and watching the words pass beneath her tongue. By some kind of interpretive osmosis the letters and sounds coalesced into a system that has enthralled me since.

Books – new books, new authors, new discoveries; the magical world of the library and the discovery, at nine and a half, of the much larger adult section. I still feel the excitement of starting a novel and realising that this is going to be a magical experience. This is the sort of book you want to savour, on the one hand greedily turning the pages to continue the story, on the other reluctantly moving forward as the ending looms too soon. Then I recommend the book to a friend and receive in return another stupendous title. And so it goes on – addicted to prose. In dire straits I will read the back of a bus ticket or a men's magazine, but never Barbara Cartland or Jeffrey Archer.

Now comes a sweeping generalisation: medical students (and many GP registrars) do not read. But there is a trend in medical education to encourage students to study the humanities. The theory goes that by exposing them to literature, they will understand the human condition and ultimately become more patient-centred. There is little evidence so far that this is the case but it seems plausible. We have all been asked to suggest the top ten books that all aspiring GPs should read. It usually starts with Balint and ends with the current literary bestseller. My list would change annually, as all top tens should. What I would warn you, though, is that if you get me started on a reading list, the whole of this journal would be smothered in titles.

Reading is imperative; writing less so. So probably I write because I read. And yes, I have the compulsory half-written novel on my PC. No, it is not autobiographical, but it is about something I know. But I am realistic. At present I am grateful to be published, even if it is an article on irritable bowel syndrome. If I had the choice, would I choose to write a work of great literary merit (how do we define literature anyway?), a blockbuster with a million sales and Harrison Ford in the title role, or a column in the *BJGP*?

No contest. You are reading this. I doubt you will ever read my novel.