The Back Pages

viewpoint

Death — usually a natural outcome, not a crime

THE Shipman Inquiry will suggest changes to the system of death certification. A discussion document[1] informs a series of seminars in January 2003 for interested parties, including the RCGP. The Inquiry's thinking is apparent in draft forms for death certification, viewable online.[2]

To summarise briefly, the Inquiry proposes a new two-page *Certificate of Fact of Death and Statement of Circumstances of Death*. The certifying doctor then progresses to the *Certificate of Cause of Death* or *Report to Medical Coroner*; another two pages. Comprehensive details of past medical history are required (for example 'details of any relevant medication prescribed for the deceased during the six months prior to death'), with specific attention to ten factors that have not caused or contributed to death — factors such as 'medical error or lack of medical care', 'an accident', or 'self-neglect or neglect by others'. Relatives will be involved, with access to the dead person's casenotes, and with similar boxes to tick excluding factors contributing to death. The level of information required will far exceed that presently required for cremation. A new post of Medical Coroner will be created — the Inquiry invites suggestions as to necessary qualifications. In turn, Medical Coroners will be supported by Investigative Officers; to assist, for example, in the investigation of the scene of death

Of course the purpose of reform, quite rightly, is to respond to the deficiencies in present procedures revealed by the Shipman case. In particular, Shipman was able to lie repeatedly on Cremation Form B to the doctors completing Cremation Form C, in the knowledge that the family of the dead person would never know what he had written about the death. Other objectives are laudable — certifying the fact of death should be formalised; doctors should know more about the details of death (like who was present), and of health before death; relatives must be more involved; systems throughout the country should be more uniform. Everyone wants to minimise the risk of concealment of unlawful death, and of medical error.

But the Inquiry must also remember that procedures must be workable, sensitive, confidential and humane. That death is usually a natural outcome, not a crime. Death is rarely as explicable, and predictable, as the Inquiry assumes. When patients die, invariably we could have done things better. To find out how, we should perform significant event analyses, not hunt for scapegoats.

If death certification follows the Inquiry route, doctors will routinely face bureaucratic hurdles and ethical dilemmas that are insurmountable. Therefore, by default, there will be a huge rise in intrusive and unnecessary coroner's inquests, often against the interests and wishes of the deceased and their families. Defensive medicine will further become the norm, and the doctor–patient–relative–carer relationship will be damaged. Funerals will be delayed. And in any event, will the proposals deter, effectively, a doctor intent on premeditated murder? Quite probably not.

This is not a moment for the profession to be obstructive. We all want to do whatever possible to minimise the chances of another Shipman remaining undetected. But can this be done without the complexity of the Inquiry's proposals? Consider one striking factor in the Shipman case — he was alone with the victim at the moment of death. This is highly unusual. It allowed him to kill healthy patients without witnesses. In our practices, with nearly 300 GP years of experience, we have only been the sole person present with the patient at death on a handful of occasions. Shipman was alone on probably every occasion.

We propose two uncomplicated, inexpensive changes to the certification of deaths in the community that could immediately reduce risk and reassure the public that 'something is being done':

- Add a question to the death certificate, completed by the doctor then handed to a relative prior to death registration. 'Who was present at the moment of death?' If the answer is a 'only a doctor', automatic referral to the coroner follows.
- Coroner's officers should investigate a random sample of deaths more fully.

Other sensible proposals emerging from the Inquiry can then be debated at length, and with proper seriousness. And with far less chance of inadvertent harm.

Orest Mulka
Alec Logan

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1. http://www.the-shipman-inquiry.org.uk
2. http://www.the-shipman-inquiry.org.uk/gencat.asp?p=2&ID=44#LIBSC85

"Can you imagine yourself in a situation where circumstances dictate that the world as you know it has perished?"

"You cannot choose life for yourself or your patients ..."

"You lack the resources to heal, even when the know-how and skills are there ..."

"You must act against your will, beliefs, ethical codes and medical oath ..."

"You are left to your own devices, facing your God and your conscience ..."

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2nd London Biotechnology Convention — London, 11 December

BIOTECHNOLOGY is humming. And shining with fluorescent dyes, and buzzing with excitement. And a lot of the excitement is here, in Britain. In his introductory remarks to the second London Biotechnology Convention, Lord Sainsbury, Minister of Science, was extremely upbeat. The government views biotechnology as one of the prime drivers for the 21st century. The UK biotechnology sector is the largest in Europe, second only to the USA. This is founded on our excellent science base and our very large number of Nobel prizes in biotechnology since Watson and Crick started the roll. There is huge collaboration with the United States. But on the other hand Europe now represents a larger market than the US itself, so we are in a position to benefit both ways.

The convention was vibrant, everyone in smart suits, everyone focused and attentive, very much a business perspective. Here were the academics meeting with the entrepreneurs and the financiers and the law firms and the head hunters and the people marketing sophisticated modelling, conferencing, team working, and referencing software. And here were sophisticated stands from the spin-out agencies of half a dozen universities. It was a festival of plasma screens and elegant graphics, mission statements and invigorating slogans. And I'm not mocking, these people were impressive. OK, the sector is a little thrown by the setbacks in the hi-tech markets, but if this is depressed, what it must have been like two years ago beggars imagination.

Inside the conference hall the story was told in a series of clipped, punchy presentations by clipped, punchy people. Precisely to time and eloquently conveying the message that nobody is messing about. They are caught up in the tight-lipped excitement of those whose career timing has gifted them a brand new technology to play with.

So watch this space — you are going to need to learn a few new words. Not that I doubt for a moment you can do it, as I said to a man on a stand, in answer to the perennial, 'How do you GPs keep up to date?', there aren't actually all that many radically new departures, and you can get most of those from the headlines of responsible newspapers, and anyway the news is repeated from many sources. But below are some of the things I picked out from the presentations to be going on with:

Forget the ethics for a moment: human embryonic stem cells are really nice if you can get them. I recommend you start calling them hESCs now. They can be made into cardiomyocytes, which not only look like heart muscle cells but also respond like heart muscle cells and in animal models can be induced to colonise damaged heart muscle and integrate functionally with the natives. That means potential repair of failing myocardium. Professor Sir Magdi Jacoub gave this as only one of a list of ways biotechnology could be applied in cardiology. If you don't want to replace damaged cardiomyocytes you may be able to genetically revive the old ones. Heart valves are not, after all, inert tissue and it may be possible to induce repair. Failing that, expect tissue-engineered replacement valves within three years. As for the problem of proliferation of the lining of vein grafts, expect an adenovirus-vectored genetic solution for that as well.

Almost all cancers got a mention in one context or another. Most cancer cells lack one or more DNA repair mechanisms (healthy cells have a number of these mechanisms) and this means that they are more dependent on the ones that remain. And this makes them vulnerable to attack by radiotherapy or chemotherapy. Drugs targeted to knock out the remaining DNA repair genes look particularly promising. Hence the importance of new 'gene silencing' techniques for targeting specific base sequences in the chromosome.

Parkinson's disease is one that researchers really seemto have set in their sights. Embryonic stem cell derived neurones have been injected into the brains of rats that have been 'lesioned' to model Parkinson's, and it seems to work. Everyone is watching to see whether the cells are rejected, or grow into tumours, but so far things are looking good. Spinal cord repair seems remotely possible, and even Alzheimer's disease, that ultimately dreadful thing, was mentioned by several speakers as potentially tractable. Now does anybody doubt that this is important stuff?

So there we have it, a very exciting picture. Can the dear old UK have really got its act together and combined its famous gift for generating new ideas with world-class development, financing, production, and marketing? It looks rather like it, and everyone was giving the government, and David Sainsbury in particular, a great deal of the credit for creating the necessary environment. Now, isn't that a nice thing to be able to say? And it looks as if we are all, doctors and patients alike, going to be the beneficiaries.

James Willis

theophrastus bombastus *flora medica*

From the journals, November 2002 ...

***N Engl J Med* Vol 347**
1447 No link between autism and MMR vaccine in this comprehensive study of all children born in Denmark between 1991 and 1998.
1483 Another study finding that heart protection from exercise is dose-related, and may be mediated by a change in lipoproteins.
1557 And another population study of 28 000 women confirming that C-reactive protein is an important independent cardiovascular risk factor — more than LDL-cholesterol.
1645 A vaccine to prevent cervical cancer? Given to women seronegative for human papilloma virus 16, it eliminated carriage and cervical dysplasia in this short-term study.
1687 A good review of transient ischaemic attacks: there is also an opinion piece on page 1713 suggesting that the label should only be given to attacks that resolve within one hour.

***Lancet* Vol 360**
1347 The global burden of disease. The place to go if you like to begin your lectures 'It has been estimated that in the coming decade, 5 billion people will die/suffer/seek medical help as a result of (insert lecture topic)'.
1447 Ximelagatran is the name on everyone's lips (if it can get that far) as the warfarin of the future: it provided equal protection against thromboembolism following hip or knee replacement in this study, without the need for INR monitoring.
1477 Heavy coffee drinking is associated with a lower risk of developing type 2 diabetes, according to this study. More support for the statement recently featured in a TV hospital comedy, that 'without coffee, the NHS would collapse'.
1531 The Multicentre Aneurysm Screening Study showed the value of whole-population screening for abdominal aortic aneurysm in men aged over 65. But the data which would allow risk stratification are absent.
1623 The PROSPER study looked at the effect of giving pravastatin to elderly people at risk of vascular disease. It also triggered an editorial complaining about the coercive effect of these cheerful acronyms (if you want to prosper, join our trial …). CRUMBLE just wouldn't have had the same effect.
1631 A big survey of primary care management of heart failure throughout Europe: could do better.
1714 Put away the peak flow meter and buy a microscope and some stains: sputum eosinophil counts are the best guide to managing moderate-to-severe asthma, with the potential to reduce unnecessary treatment.

***JAMA* Vol 288**
2123 Prior use of hormone replacement therapy protects against Alzheimer's, but once you have it, it's too late.
2144 Less than half of clinical heart failure in the elderly is associated with a lowered systolic ejection fraction: 'diastolic' failure in stiff old hearts gets an excellent observational study here.
2271 Keep your brain active and your cognitive abilities will remain good over the age of 65.
2307 But you still may lose your sense of smell if you live beyond 80 years (60% risk).
2411 Two antiplatelet agents are better than one following percutaneous coronary interventions: we shall probably be adding long-term clopidogrel to aspirin in many of our patients.
2441 And warfarin is better than aspirin in every subgroup of patients with atrial fibrillation (meta-analysis).

Other journals
***Arch Intern Med* 162: 2278** follows up 8816 postmenopausal women for 10 years and finds that continuous HRT users have a 20% risk of non-vertebral fracture. ***Ann Intern Med* 137: 798** finds that use of HRT for more than five years combined with more than 20 g of alcohol per week doubles the risk of breast cancer. What about alternatives remedies for menopausal symptoms? Page 805 gives the review you need — soy may or may not work, and black cohosh does work, but may be too directly oestrogenic to be safe for hot flashes (we say flush, they say flash, let's call the whole thing off).
***Spine* 27: 2564** is a review of cognitive behavioural therapy for all kinds of pain, not just spinal. 'Helps many patients,' it concludes. ***Thorax* 57: 967** looks at 20 000 Danes to see if stopping smoking really does reduce COPD morbidity. It certainly does — by 40%, whereas merely cutting down has little effect.
Planning a round-the-world trip? ***QJM* 95: 723** has good news about spider bites in Australia — most are trivial, but it may still be worth looking under the toilet seat for redbacks. However, avoid exotic dishes in the Philippines (***Neurology* 59: 1664** Cycad neurotoxin, flying fox consumption, and ALS/PDC disease in Guam).

Plant of the Month: *Daphne bholua*
This is the plant of the entire winter season, if the weather is kind: evergreen and covered in pink intensely scented flowers from Christmas to Easter. But a single hard frost can kill all the flowers and the leaves too. Still worth growing, because it usually recovers well.

An oral history of general practice 8: Patients and populations

In the past 50 years the transformation of the doctor–patient relationship in general practice has included the weakening in the deference of patients towards doctors, the decline of the 'traditional personal intimacy' of the doctor–patient relationship, and the increasing effectiveness of general practice medicine which, along with an arguable rise in the culture of consumerism, has helped to raise patient expectations. Examples of these and other changes in society, in patient attitudes and in general practice provision have been charted and illustrated using oral evidence.[1] If, however, we listen to the voices of practitioners,[2] this known history is confirmed *and* we gain new insights into the qualitative changes in the relationships between doctors and their patients.

Older retired GPs in the Paisley study[3] often enthusiastically talk about home visiting in the 1950s that once was central to the doctor's day, and just as often are significantly silent about the work they carried out in their surgeries at that time. Partly, this is because these doctors wish to emphasise their belief that the subsequent decline in house calls was a significant loss to general practice. But it also seems that seeing patients in their home environment was quite different from the demands of a surgery full of patients in a time before appointments, and with only limited access to diagnostic tools and therapies.[4] Similarly, older GPs often describe their involvement in obstetrics in positive terms. In these narratives doctors are appreciated for being on hand and for at least being potentially useful. Disappointingly for these practitioners, and in the space of a few years, the several hundreds of home births that partners in a medium size practice could find themselves involved with were all but ended and hospital medicine had taken over a task that they believed had been central to family doctoring.

The pleasant drives in a relatively traffic-free town to call on reasonably undemanding patients' in their homes had given way during the 1960s to an escalation in house calls, fuelled at least in part by the growing numbers of patients with access to telephones. Some of the GPs point out that they felt obliged to respond to this demand, rather than risk patients' complaints, regardless of whether a visit was clinically indicated or not. Those who entered practice from the mid-1970s onwards experienced a reduction in the number of house calls. Home visiting was also increasingly believed by doctors to be a waste of their time and, it was argued, more patients could be seen more efficiently in surgeries that many GPs had recently improved. More effective team working, especially with district nurses, further reduced house calls,[5] and more recently some Paisley practices have adopted triage systems that have almost eliminated home visits and it is claimed that the out-of-hours co-operative has encouraged patients to make daytime visits to their own GPs. Even those GPs — and there are many in the town — who pride themselves on practising with care and kindness reported that they had become 'a wee bit harder … less tolerant' with patients who fail to keep appointments.

If time is the 'real currency of general practice'[6] then it is the currency of a token economy, with practitioners historically valuing their time as precious. The GP narratives suggest that patient behaviour requires moderating by rewarding or denying patients their doctors' time. However, by insisting that general practice is more efficient if patients are provided with appointments to attend surgeries and clinics, GPs have increased their daytime workloads and decreased the time between consultations.

The doctor who listens to non-medical problems remains a valuable resource to patients, according to a number of the Paisley GPs who were interviewed. In doing so, parallels were drawn between the pastoral role that was once filled by organised religion and their own work as GPs. Many of the GPs expressed a strong sense of egalitarianism in their descriptions of the doctor–patient relationship and some of the younger doctors stressed that they maintained a sense of patient advocacy that had been more of a feature in the work of the older generation.

The oral evidence also suggests that even in a town such as Paisley, with deep deprivation, some practices were much more likely to have a patient population that was drawn from the poorest sections of the population. Indeed, the majority of working practitioners were keen to stress the value of having a patient population that was socially mixed. And while there was an acute awareness of the depths of deprivation in Paisley, there was little sense of agreement about how general practice could, or even should, tackle such poverty. Some of this ambiguity seems to have arisen as a result of the rise of a patient-centeredness and emergence of 'mass medicine',[7] which appears to be more easily practised with 'mixed' rather than 'deprived' populations.

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The oral evidence

Hector M entered practice in the 1940s.

'There was a lot less trivia in these days. People only went to see the doctor if they had to and home visits were done on a regular basis... return visits to chronically ill people were done once a month... "I'll just look in and see you next month", so you did. It was much more friendly and you knew your patients.'[7]

Two decades on, Donald W joined another Paisley partnership.

'I mean the demands for house calls in the 60s hugely outweigh anything that we get now ... and a vast amount of that would be just trivia. And while it's important in getting to know the background of people, if you've got a lot of calls to do there's too much pressure on you to actually appreciate that.'[8]

In the late 1950s Charles McC joined his father and older brother in practice.

'Home births was where you got to know the patient. You sat up with the patient and you delivered the baby. You'd had a cup of coffee and a smoke. I smoked in those early days ... It was exciting ... When you're young in medicine you like excitement ... You had to be kind to people that weren't all that capable of defending themselves. It is easy to beat someone who has got no defences. My old man used to make the comment, "Never oppress the poor". And the oppression of the poor was quite an interesting concept, because it went through a lot of things. For example if some old buddy [resident of Paisley] *offers you a cup of tea. It's a kind of miserable looking cup. You don't particularly want the tea, but you damn well sit down and have that cup of tea, because you are otherwise offending the person who is offering you hospitality ... you had to respect people's dignity ...'*[9]

Other GPs who entered practice in the late 1970s to early 1980s found that their time was limited and that home visits were increasingly difficult to justify to themselves.

Damian S: *'At the time it seemed quite fair, but on hindsight ... it was bloody unfair. It was shocking in fact. So for the first year or two of Mondays* [circa 1978] *you were seeing 30 people in the morning, ten or 15 house calls depending on summer or winter, and 30 people in the evening. You got to learn to consult very quickly. ... Well, as I say, the old adage "I saw thirty people today". Nobody ever says, "I saw and examined thirty people today".'*[10]

Fiona T: *'The days of monthly home visits to elderly people at home — I wasn't ever quite sure why I went back, I left some prescriptions, you know that kind of visit* [laughs]*'.*[11]

David D: *'At the end of the day doing house calls is just an extremely time-consuming way of seeing patients.'*[12]

The decline in home visiting has not always been straightforward as this GP recalls.

'Patients are less demanding because they are now being conditioned. Now I think for a couple of years before we came into the practice in 1975 they had been using the deputising service. Shortly after we came into the practice I got a call one night from a patient, "Oh, it's you doctor, Oh, I thought it was the emergency doctor that was on, Oh, I'll wait till the morning".'[13]

The commercial deputising service was replaced by an out-of-hours co-operative in the 1990s.[14]

Christopher J: *'The difference the [out-of-hours] system has made is that people phoning on a regular basis get the same message about when you should or shouldn't call the doctor out and whether its appropriate or not and our house calls have fallen. People have been educated ...'*[15]

Most of Paisley's practices attract patents across the social spectrum.

Fiona T: *'It's a lovely* [practice] *population of two, three at least, generations of families. They stay very, very loyal to the practice ...Very much spread across the town ... the geographical spread and the social class spread of the practice ... I think it's nice not having an imbalance. I think it's good to have a variety of folk.'*[16]

Robert E recalled one of the first practitioners to establish a practice outside of the town centre.

'And a lot of the doctors in Paisley were quite pleased, because they got rid of a lot of patients who had been giving them a lot of hassle and trouble ... It was a very [pause] *deprived part of the town ... Took quite a few of them off their hands and then he took on a partner. They have both retired and there's two or three new people there whose names I don't know at all.'*[17]

For a number of years Dr Wasim B and his two colleagues have served the most deprived area in Argyll and Clyde. In 1999 the practice was unique in Paisley in offering patients appointment free daily sessions.

'In the long run the patients are you know, quite good. I mean they can be tamed, or they can be civilised through certain aims. Because we treat them like human beings — some of them — that doesn't mean it's a general principle. Some of them like alcohol, drugs ... We had a lot of difficulty in convincing them that some of the drugs are harmful to your health. You know an individual who used to come to consult us and they were forcing us to prescribe some of the drugs and there were some bitter relations between the patient and the doctor.'[18]

Others share his enthusiasm.

Andrew K: *'We were the second most deprived practice in Paisley ...We have more than our share of social class V ... I enjoyed working here, because ... your own background is relevant in a situation like this. I could identify very strongly with the people in the practice ... solid working-class people. So I have a great empathy with them ... I had no difficulty eh, transferring into this environment because it's something that I was used to ... Because you have so much power in that situation, you have to be careful that you don't become superior, because the patients are vulnerable anyway. So I think you have a bigger responsibility treating people from the lower social class. ... I would say I do feel happier dealing with this section of the community, because it is worthwhile. Having said that I wouldn't like to be working in a very deprived area and nothing else but that but having a, what we have is quite good.*

'... You could lose your humanity towards people, because your treating them less than yourself and when you start doing that your own values begin to go and you start looking down on people ...'[19]

Graham Smith

Medicine and the Holocaust - lessons for present and future physicians

'It is all about our conscience'

ALMOST 60 years after the end of World War II, interest in the Holocaust, paradoxically, seems to be growing. There is still a need for contemplation. Leaders of 50 nations assembled in Stockholm in the year 2000 and declared that 'the Holocaust (Shoah) fundamentally challenged the foundations of civilisation … With humanity still scarred by genocide, ethnic cleansing, racism, anti-Semitism and xenophobia, the international community shares a solemn responsibility to fight those evils … We pledge to … promote education, remembrance and research about the Holocaust …'[1]

It is not surprising that today there is more interest in the Holocaust than in 1945. Many feel that at the dawn of the third millennium, the memory of the Holocaust is an essential component of human identity. Because of this, many commemorative and educational activities worldwide aim to remember the spectre of the Holocaust.

For health professionals, there are distinct messages. The Holocaust raises many questions for medical ethicists.[2-4] The submission of the medical profession to a murderous ideology led directly to the Nuremberg Code (the first code on human subject experimentation).

In this paper we wish to illuminate, as comprehensively as possible, lessons derived from the Holocaust, that can inform today's health practitioners. Our observations are based on personal experience as practitioners and educators, combined with academic study of the subject.

For three years, Shmuel Reis lived and worked in Lohamei Haghetaot, a kibbutz in northern Israel. Lohamei Haghetaot is Hebrew for 'the ghetto fighters', and indeed, survivors of the Warsaw ghetto uprising of April 1944 founded it in 1948. About one hundred of his patients in the kibbutz are survivors, now in their 70s and 80s. A major physical presence in the community is that of the Ghetto Fighters House (GFH), a museum and study centre commemorating the Holocaust.

His main practice, based in a health centre in central Galilee, has about 6500 patients. During a typical working day, seeing between 40 to 50 patients, the subject of the Holocaust will usually come up several times. Such figures are quite typical of many general practices in Israel.

We also teach medical students, family medicine residents, and practising physicians. During one of the small group discussions, a student said: 'It all has to do with our conscience as future physicians'. This was a moment that gave meaning to our efforts. Since 1999 study days have been held on Holocaust Memorial Day each year.

So far we have identified five major areas from which conclusions can be drawn for present and future physicians.

Firstly, and most obviously, there are lessons for present and future medical ethics, well documented in the literature.[3,5,6] With scientific progress in genetic testing, the human genome project and other interventions on the horizon, eugenics is again rising to prominence.[7] Health care policy issues, such as resource rationing and dual/triple accountability, once again bring the conflict of individual versus public welfare to the fore. Clinical dilemmas surrounding euthanasia, abortion, transplantation, and establishing death are a constant reality. Research dilemmas exist around clinical trials, human subject experimentation and the like. Our days abound with questions that can be informed by studying the Holocaust.[8]

A second, perhaps more personal lesson, is that of surviving and functioning when faced with extreme situations and impossible choices. The list of physicians who committed atrocities is complemented by that of the physicians who stayed true to their humanity and vocation.

Dr Janusz Korczak, for example,[9] a paediatrician turned director of a Warsaw orphanage, led his 200 protégés to their deaths in Treblinka and refused the offer to save himself. Weinryb, in Ghetto Vilna, organised a fake ward to protect the lives of typhoid epidemic victims;[10] Milikovski and Falk continued to practise, research, and teach in the ghettos and camps.[11]

A play by Israeli playwright Joshua Sobol, *Underground*,[10] portrays the terrible circumstances ghetto physicians had to confront. Jewish physicians in the ghetto faced terrible dilemmas: births were forbidden and even their scarce medications had to be rationed. Individual care versus danger to the public was a constant conflict. The physician was required to choose between the sick and the healthy, the rich and the poor, the old and the young on both medical and administrative issues, while facing the same fate: ultimate destruction. Inner struggles were a constant reality: should one take personal risks in order to care for patients? Stay behind or attempt to save one's own life? Forge medical documents or destroy records? Ghetto and camp life also eradicated all traces of any former higher status.

Guilt, insanity, criminal behaviour, along with heroism, kindness and generosity — all of these are potential reactions to such terrible choices. This is a case of living in an abnormal reality and creating an alternative whereby the abnormal becomes routine. Can you imagine yourself in a situation where circumstances dictate that the world as you know it has perished? You cannot choose life for yourself

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or your patients. You lack the resources to heal, even when the know-how and skills are there. You must act against your will, beliefs, ethical codes, and medical oath. You are left to your own devices, facing your God and your conscience.

A third area of concern is medical care of the survivors and their families, wherever they live in the world.[12-14] One cannot care holistically for this community without knowledge of the history, names, places and possible consequences of surviving World War II, or growing up in a home where one or both parents are survivors. It calls for appropriate listening and communication skills. It calls for specific therapeutic interventions, all requiring imagination. It calls for you to put yourself in your patient's place (see the example opposite).

The fourth dimension is one that we are more hesitant to bring up, yet it may be the most important. It refers to the potential murderer in each and every one of us, the need to be aware of it and suppress it.

Numerous experiments, experiences, and studies point to the fact that, given the right circumstances, we are all prone to cruelty, blind following of a powerful evil, and racism.[15] Being caring physicians and model, religious family men did not protect many Nazi doctors from committing the most abhorrent acts within the scope of their profession.[16]

We all know that, looking at world history since 1945, numerous examples of 'ethnic cleansing' and genocide (for example, in the former Yugoslavia and Rwanda) show that the lessons which should have been learnt from the Holocaust have not been.

We are aware that some people think of Palestine in this context. To equate a war on terrorism with genocide is a gross distortion of a very complex situation. At the same time, most Jews agree with the British Chief Rabbi Jonathan Sacks when he said that 'there are things that happen [in Israel] which make me feel very uncomfortable as a Jew'.[17] We also know that many Muslims feel very uncomfortable as Muslims about some events of the Intifada. If only for pragmatic reasons, much will have to change on both sides to turn hatred into goodwill, and so to peace.

Israel Charny, a professor of psychology at the universities of Tel Aviv and Jerusalem, is a scholar in this field. He lists the following as some of the precursors of decent people becoming evil: obedience to authority; the power of the mass and the leader; stress and anxiety reducing quality of power; ideology; persecution; and the dynamics of rationalisation ('they deserve it') and that of the bystanders who watch and ignore the cries for help.[15] Many of these precursors are based on prejudice*, imprinted and fixed in people's minds through propaganda — a basic tool of totalitarian regimes.[18]

Is this information effective? We cannot provide you with any evidence on the matter. However, 'Not because of basic evil, but as part of human nature, we tend to obey blindly, to be intoxicated by power when in charge of others, to continue our routine and justify the establishment, to project on minorities our own feelings of inferiority and frustration, to become ecstatic in a rallying mass, especially behind a flag, to deny the wrong that our own nation and we ourselves are committing to a minority we oppress'.[15]

Is it not our duty as human beings and as professionals to take pains to study, remember and teach these facts even if we do not yet have evidence of the effectiveness of such teaching?

The fifth dimension is that of resilience,[19-21] 'a construct connoting the maintenance of positive adaptation by individuals despite experiences of significant adversity'.[18] It is now fairly extensively dealt with in the post-traumatic stress disorder and child development literature. It is an attempt to document, explain, and eventually intervene in order to promote resilience in extreme situations. Some of this research is done with Holocaust survivors and their offspring, the most remarkable example, probably, of human resilience (and its lack) in recent history. What enabled so many survivors to reclaim their lives, and lead a normal life after the Holocaust, while a minority succumbed to psychiatric morbidity of various degrees? Victor Frankl[22] is probably the best known scholar of this issue, teaching us the central role of purpose and meaning as protective against adversity. Many scientific problems still limit the practical application[16] of this construct, yet its study and contemplation seem worthwhile.

We have tried to share with you five domains of lessons to be drawn from the Holocaust in order to enhance the field of medicine and serve both present and future physicians. We have described our initial efforts at implementing these lessons at one medical education institute in Haifa, Israel.

It is all about our conscience.

Shmuel Reis
Tomi Spenser

Example

Albert, a 73-year-old male frequently appeared at the clinic, often with scraps of paper, along with lists of questions, making his doctor quite uneasy. On the brink of losing his sense of compassion, the physician found out about his Holocaust history.

He was 10 years old when the Germans occupied his hometown and he was deported to the ghetto at age 12. One by one his father, older brother, then his baby brother and mother died of hunger. He and his younger brother became streetwise kids, learned how to get food and how to come and go across the barbed wire. They broke out of the ghetto, looking for relatives. They stayed with one, then moved on to another. They became vagabonds, with only their clothes on their backs. When the snowy winter began, his younger brother fell ill and died. He was left alone, roaming southern Poland. He stayed on farms and when he sensed danger, he moved on, like a hunted animal. He crossed borders into Hungary and Slovakia, without realising it, then tried to cross back. He became a partisan at the age of 15. He was wounded when his unit was attacked. He barely escaped and found himself on the road once again. In March 1945, he stumbled into a Russian unit. When sailing in an illegal vessel, he was caught by the British and deported to Cyprus. He finally reached Israel in the latter part of 1947. He fought in the War of Independence and then joined a kibbutz.

How can one not be compassionate towards Albert? After reading his life story, the patient–doctor relationship completely changed. Over the next two years he visited the clinic relatively rarely. He had major medical interventions, which went remarkably well, both physically and emotionally.

Lessons for today's health practitioners from the study of medicine and the Holocaust:

- the impact on professional ethics today
- the practice of medicine in impossible circumstances
- the care of survivors and their offspring
- the suppression of the destructive potential in all of us
- the capacity (or lack of) to withstand severe adverse life circumstances (resilience)

*The Concise Oxford English Dictionary defines prejudice as 'a preconceived opinion that is not based on reason or actual experience; unjust behaviour formed on such a basis'.

This article is based on a lecture delivered at the WONCA-Europe conference Vienna, Austria, 2000.

War, peace, and the 'relaxing pill'

TRANQUILLISERS and hypnotics are in relatively high use, and have resulted in serious health problems in several parts of the world. In France and Italy, 13% to 25% of the general adult population are occasional or regular users of these medications.[1,2] Lebanon witnessed a marked increase in the use of tranquillisers after the end of the wars in 1990. What follows is a brief summary about the conditions in Lebanon between 1975 and 1999, which are thought to have a direct bearing on the sharp rise in the use of tranquillisers in the post-war years.

Lebanon covers an area of 10 452 km^2 and has a population of around four million. Eighty per cent of the Lebanese live in urban areas. In 1998, the ratio of physicians and pharmacists per 10 000 populations were 21 and five, respectively.

Between 1975 and 1990 the country witnessed a series of wars among several factions. In 1976, a peace-keeping force, mainly consisting of Syrian troops, succeeded in enforcing peace for few years, after which these troops were involved in direct and fierce clashes with several Lebanese factions and Israel. In 1978, Israel invaded the South of Lebanon and in 1982 the Israeli army invaded large territories of Lebanon, including the capital, Beirut. Several massacres took place during the fifteen years of war; most notably at the Sabra and Shatila refugee camps, two camps inhabited mainly by Palestinian refugees.

The war period, which ended in 1990, was characterised by absence of legislative power, total chaos, and over-the-counter dispensing of almost all medications.

In 1999, nine years after the cessation of the Lebanese wars, more than 1 600 000 packs of anxiolytics and hypnotics were dispensed, compared with fewer than 800 000 packs during the ninth year of war[3] (Figure 1). The increase in consumption of anxiolytics and hypnotics is thought to be owing to several factors, which include war-related factors and the ease with which these medicines could be obtained. We refer to these anxiolytics and hypnotics as the 'relaxing pills' — that is how they are perceived by the Lebanese people.

War-related factors

Socioeconomic

After 1990, the economic situation started to deteriorate. The Lebanese had to cope with an increasing daily cost of living and a decreasing income. In 1995, 28% of Lebanese families were living below the absolute poverty line, which is defined as extreme deprivation of basic human needs,

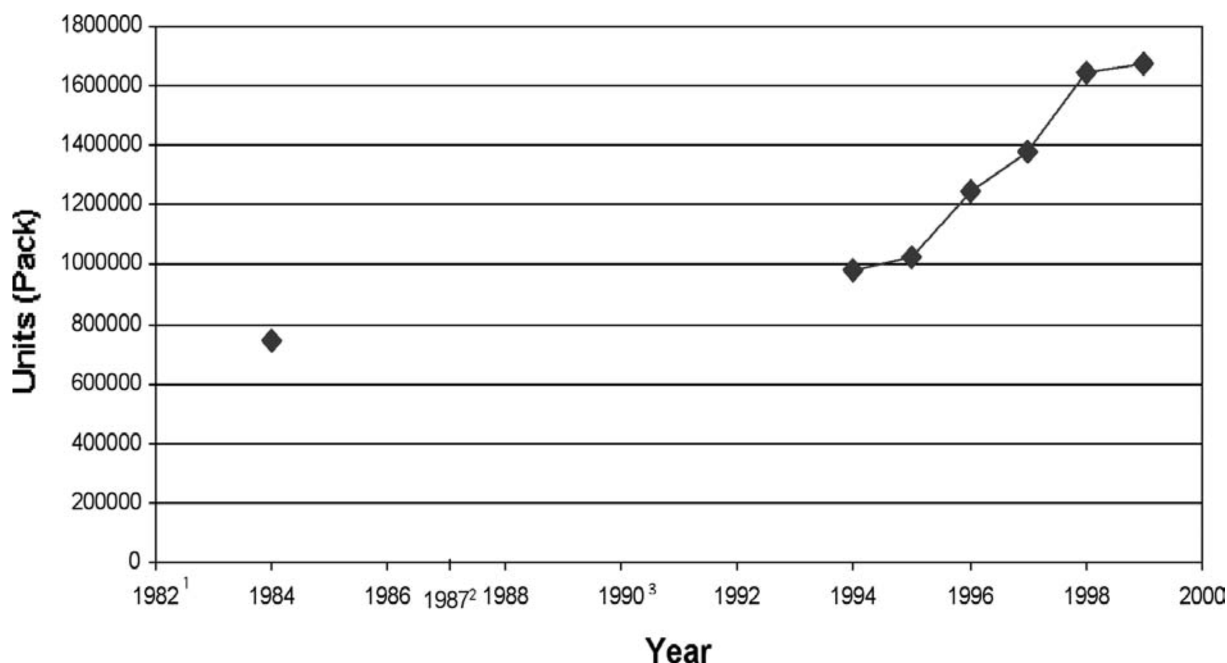

Figure 1. Rate of consumption of anxiolytics and hypnotics during the Lebanese wars.

Chronology of significant events:
1: Israel invades Beirut; Syria withdraws from the capital; Sabra & Chatila Massacres.
2: Syrian troops enter Beirut.
3: End of Civil War.

including food, safe water, sewerage, health care, education and shelter.

With the beginning of peace, the government resumed tax collection. Residential rents rose by 64% between 1994 and 1996. The bill for utility services and the price of fuel also increased substantially. Concomitantly, unemployment rose from 8.1% in 1970 to 10.4% in 1987, and then to 20% in 1999. The real GDP dropped from US$ 6880 in 1985 to US$ 4161 in 1993.

The effect of the rapidly deteriorating economic situation on the psychological wellbeing of the Lebanese individual is not to be underestimated. To make ends meet, people tend to work more and socialise less. Hence, social support is diminished and the stress is more pronounced. The 'relaxing pill' may provide an easy way to cope with the situation. It is known that periods of political and economic transitions are associated with an increase in psychological morbidity and mortality.[4]

Psychological
During the Lebanese wars many people were uprooted from their homes and forced to move out. Many had to move more than once, in search of a safe haven for them and their families. In addition to the feeling of insecurity and instability, the Lebanese individual had to deal with disrupted sleeping patterns and struggled to ensure the basic needs for self and family amid the multiple challenges of everyday life (closure of schools, power failures, interruption of water supply, rationing of food). The 'relaxing pill' was a convenient and comforting escape.

The children of the 1970s became the adolescents and adults of the 1990s. Mothers exposed to war-related events are more likely to develop psychological problems, and symptoms of depression among mothers are associated with increased morbidity among their children. Yabroudi *et al* demonstrated that Lebanese adolescents whose parents take tranquillisers are more likely themselves to become users of the 'relaxing pill'.[5] This observation may explain the increased use of anxiolytics and hypnotics at present in Lebanon.

Access to medication
The physician factor
Lebanese physicians tend to prescribe anxiolytics to alleviate their patients' distressing non-specific anxiety-related symptoms. The physician often finds himself pressured by the patient to provide a rescue remedy or a relaxing pill. Also, lack of knowledge of sleep hygiene and the different stress management techniques, or the limited time allocated for a medical consultation, make prescribing a pill a quick and convenient alternative.

The symptomatic improvement of the patient is a 'good' reason for the doctor to provide a refill on an ongoing basis.

The physician's role in allowing people to become habituated to psychotropic medication is well documented. Sleath *et al*, for example, found that, although patients initiated 42% of psychotropic prescriptions, the majority of medications were previously prescribed by a physician.[6]

Uncontrolled dispensing by pharmacists
For several years, medications could be obtained from pharmacies in Lebanon without a prescription. Self medication was observed in 53% of adults admitted to a Lebanese hospital for drug-related illnesses; hypnotics and sedatives were the second most commonly used group in self-medication.[7]

During the Lebanese wars, the existing laws restricting the purchase of certain medications could not be enforced, and there was no control over patient access to psychotropic medications.

This problem persisted after the wars ended and was compounded by the financial motivation for pharmacists to encourage unlimited sales of these medications. Between 1975 and 1998 the number of registered pharmacies increased by tenfold.

Recommendations
It may be difficult to control the economic hardship of a country with few natural resources that has witnessed complete destruction of its infrastructure and a draining of its financial and human resources. Yet, reduction in the use of anxiolytics and hypnotics may be possible, by putting into action the following:

- Promoting the skills of physicians in different stress management techniques that may help with managing anxiety symptoms, without the need to resort to medications.
- Educating and training physicians about sleep hygiene and the management of sleep disorder.
- Reducing the common practice of over-prescribing by educating caregivers that patient satisfaction correlates directly with the time spent with the physician and improved understanding of the disease, not with receiving a medication.[8,9]
- Making sure that anxiolytics and hypnotics are not dispensed without a prescription.

Bassem Roberto Saab
Namir Damluji
Najla Lakkis
Jinan Usta

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Using information and communication technology in healthcare — Stuart Tyrrell (Radcliffe
Medicine and the Internet (3rd edition) — Bruce C McKenzie (OUP, 2002, PB, 296pp, £14.9
Evidence-based medicine toolkit — Douglas Badenoch, Carl Heneghan (*BMJ* 2002, PB, 64p

'THE creation of the PC is the best thing that ever happened', said Bill Gates at a conference on the digital divide in 2000. Well he would say that, wouldn't he? But there is no denying that computers, and especially the Internet, are providing challenges and opportunities in equal measure and at an unprecedented pace to boot. At the heart of the challenges and the opportunities is the ease with which it is possible to generate and exchange information. Information is the lifeblood of health care, so it is not surprising that information technology (IT) is seen as the Next Big Thing in healthcare. That IT has been the Next Big Thing for years shows how difficult it is to realise this potential. The British government has showed renewed seriousness by recently earmarking £12 billion over five years to improve the National Health Service's IT infrastructure.

These three books, each in its own way, aim to help clinicians make better use of information and the technologies that provide it. Stuart Tyrrell aims 'to assist staff in the health sector to harness health information confidently and effectively.' To cut to the chase, Mr Tyrrell fails to achieve this aim. In the main, clinicians (and a good many others) do not want to know how their computer goes about its machinations, but would be interested in knowing the best treatment for Mrs Smith's sick child. While the book does offer some useful overviews, it will not light fires in the minds of medics hoping to become IT-savvy. The book is far too general to warrant the word 'healthcare' in the title and will be of limited use to clinicians needing advice on how to make better use of IT in their practice.

For that, Bruce McKenzie's book would be a better choice. Many things compete for a clinician's time; patients and paperwork but also the telly and family. Richard Smith, editor of the *BMJ*, has said that those providing health information should make it sexier if people are to divert themselves from, well, everything else. 'Medicine and the Internet' nods in this direction by having short chapters and visual cues to help the reader

Physician, heal thyself: the NHS needs a voice of its own
Duncan Smith (Spokesman Books, 2002, Socialist Renewal Series - 1, Pamphlet, 40pp, £4.00

THE author of this book became Chief Training Officer of the National Health Service in 1967, having spent his active working life in nationalised industries. He documents, in easily understood and vivid language, how the politicians have walked like 'elephants in the jungle', trampling the goodwill of a service industry, where the wisdom of those working within it has been systematically ignored.

His main thesis is that within this large organisation there has been a systematic attempt to develop a culture of active learning, and successive governments have ignored feedback from those who serve. A good physician listens, observes, investigates if necessary, and then makes a decision to act. To monitor the success or failure of the process in reflective practice is axiomatic. For the service as a whole the task then becomes to provide a constitutional method to 'take the temperature of the service' and to implement change in a dynamic and organic way.

He proposes that, whereas health requires an integrative and co-operative working relationship between health, community and social service provision, separatism has been built into successive reorganisations. He recommended, while Chief Training Officer, the development of a 'staff college'. This did not progress after Keith Joseph, then Secretary of State for Health and Social Services, found that other major departments concerned with health wanted the same mechanism. Problems of integrated working was further compounded in the Thatcher era, where the internal market was developed as the catchphrase but where patients did not have freedom to choose — some market! And where the provision of care was not matched by quality control! And yet in Northern Ireland Health Boards such provision was already in place, bringing together health, social service, and local authority provision. I observed at first hand this successful model when seconded to the clinical standards advisory board in 1997 and also saw first class organisational audit working across boundaries at the general practice level.

He makes a powerful plea for the establishment of a staff college, able to discuss and formulate recommendations from those working within the health and social services, and informing the health executive of areas where a change in public policy needs to be implemented. In other words, a 'bottom-up' approach to communication with staff, as well as informed leadership. He is scathing about initiatives such as the private/public partnership and the failure to plan for the staff levels required in the development of a modern service. Is it too late to return to co-operation and the distillation of excellence, where those who serve the NHS do so with a sense of service and pride, rather than defensiveness and overload, generated by a 'top-down' management deluge? He points out that there has been reorganisation after reorganisation, in which management consultants — with far less experience than the providers — work with politicians eager to make their names

overheard in New Orleans...

A presentation at the North American Primary Care Research Group Conference on a small study on medical error in Cincinnati. Eight or so practices involved ... 'None of these practices have electronic records ... [pause] This is Cincinnati. Of which Mark Twain wrote that he would like to be there when the world ends, because everything comes to Cincinnati ten years later.'

2002, PB, 156pp £19.95, 1 85775469 7)
, 0 19851063 2)
p £9.95, 0 72791601 7)

reach content quickly. There is plenty on how the Internet could help you with your clinical practice and research but relatively little about the technology, which, frankly, most people don't care about. Website addresses come in spades, which can sometimes be irritating, but the book is about the Internet so suggesting where to look is perhaps the whole point. Finding the evidence upon which to base your evidence-based practice is often a problem, so Andrew Booth's chapter on accessing the evidence is particularly welcome. It makes a good starting point for anyone at a bit of loss as to how the Internet might actually help them become a better doctor. One point though: the full Cochrane Library is now available free in many countries, including England. Writing a book about the Internet is doomed to be out-of-date while the ink is still drying.

The last of this trio is a bit different, since it is not about information technology, just information. Or rather, how to make the best use of information. It is small enough to stuff in a shirt pocket and is easy to read. Dip in between walking the dog and *Friends*.

0 85124667 2)

and to change service provision, by revolution rather than evolution. In the process the management costs have increased to 5% of health service costs in 1980, and to 12% in 1997!

In the UK the population still largely supports the health service, even though the NHS receives only two-thirds of the income of our European partners. He draws attention to the need to see human health as a co-operative venture between medicine, community facilities, and social services, and that your health is directly affected by your income if you are in the poorest quarter of the population. He makes a plea for a return to rehabilitation and, where possible, resettlement of older people in their own homes, and sees the possibility that the new primary care trusts may begin to plan a more appropriate service. He finds it strange that the local authorities are not represented as a voting representative on the new boards. And where is the public? In school governing bodies we see how important a contribution the general public can provide.

Duncan Smith offers us a comprehensive and vivid portrait of political short-termism, and solutions that the government might be well advised to develop as policy.

As a general practitioner who retired early because of the increasing bureaucratic control and difficulty in practising the craft I love, I recommend this astute analysis.

David L Beales

1421: The year China discovered the world — Gavin Menzies
Bantam Press, November 2002
HB, 389pp, £20.00, 0 59305078 9

GAVIN Menzies is a retired Royal Navy submarine commander and enthusiast for ancient maps. He noticed something odd about a map drawn in 1424 by a Venetian cartographer, Zuane Pizzigano. The map showed four islands in the Western Atlantic with towns marked on them, and unknown names. After allowing for errors in calculating longitude and comparing it with other charts he became convinced that the islands named Antilia and Satanaze on the map were in fact the Caribbean islands of Puerto Rico and Guadeloupe. He concluded that someone had accurately surveyed them seventy or more years before Columbus reached the Caribbean.

This was the starting point for a fascinating quest to discover who could have been responsible. He uncovered maps of Patagonia and the Andes dating from a century before Europeans visited them, and accurate charts of Antarctica, Australia, the Arctic, and the Pacific and Atlantic coasts of North and South America centuries before Europeans arrived. The cartographers would clearly have had to be skilled navigators and seamen, and the extent of their exploration suggested that large resources, including many ships, had been used. Yet this massive achievement appeared to have been completely forgotten by history.

Menzies describes events in the reign of the third Ming emperor of China, Zhu Di who built a vast fleet of ships, including 400-foot-long, nine masted 'treasure ships'. On 8 March 1421 a fleet of more than 100 ships set sail from Southern China under the command of the eunuch admiral Zheng He, to chart the oceans and bring the entire world into China's sphere of influence.

Two years later, less than a tenth returned, bringing stories of having visited '3000 countries'. During that time a series of disasters had struck China, including the destruction of the newly built Forbidden City at Beijing by fire, and political collapse. The records of the voyages, the plans of the ships and the shipyards themselves were destroyed. China turned in on itself and avoided contact with the outside world.

Menzies presents evidence from his knowledge of navigation, from accounts of Venetian travellers, and from anthropology, archaeology and horticulture, to support his hypothesis that Zheng He's subdivided fleets charted the greater part of the world. He argues that there are traces of Chinese influence throughout America and even in the stories of Australian Aborigines. His main weakness is that his enthusiasm for his theory leads him into not considering alternative explanations for some of the evidence he presents. But that is a small complaint against a compelling and thought provoking book and I thoroughly recommend it.

Toby Lipman

What's in a font size?

It's interesting, I think, to see
A GPSCI[1] and a GPWsi[2]
Then there's a GPwsi[3], and
GPwSI[4] to lend a hand

Is this a crisis in I.D.
Or id?
An oversight?
I shall argue for insight

Be sure, the font is writ with good intent
The emphasis is surely meant
To show
The way each author's wind does blow

The GP *W*si must be a generalist
It is the *WITH* that time will test.

SI shows a new departure ….
But weren't our patients interesting
(and special) heretofore?

The *C* denotes a claim to competition —
*C*onsultant after all has such a start
And it is *c*linical acumen that we mark here
(Otherwise, why not E and R*,
which do not seem to figure).

Perhaps its *GP*wsi that knows the score
GP comes first in all, and non-disputed
But it is in the rest that strife is mooted.

So let **GP** stand out, the rest is an aside
It is the big **GP**
That makes a case
For pride.

Amanda Howe

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*E&R = education and research

reflection

Once more unto the breach, dear friends ...

Acknowledgement
My co-facilitator is Atle Klovning, general practitioner and bon viveur *of Bergen, Norway, who grew in our estimation by the poise with which he sent back a corked bottle in a Durham wine shop.*

The day after my return from the Fourth Northern and Yorkshire Evidence-Based Practice Workshop I was shattered. I had spent a week facilitating a small group in its struggle with critical appraisal, odds ratios, and the usual things that happen in small groups of strangers who are out of their comfort zone and thrown together for a week. My house was full of teenagers who weren't exactly committed to facilitating my search for well-deserved relaxation. So I turned on the radio and listened to the Last Night of the Proms, which included Walton's music for *Henry V* and some of Shakespeare's words. They evoked a weary chord in me and much ruminating on why we do this year after year.

Between us, my co-tutor and I have spent around six months of our lives facilitating small groups at EBM workshops. We have learned a thing or two. The first thing is that whatever you do to prepare prospective participants for a workshop will be wrong. If you send out the resource pack before the workshop, they will say there was too much to read and there was no point in sending it. If you give it out when they register they will say that they would have liked it earlier. The second thing is that groups really do form, storm, norm and perform — not necessarily in that order. I have been in groups that have been going along at a cracking pace by the second or third session (i.e. apparently performing) only for a storm to break out the next day. The moral is that there is no gain without pain — or if you prefer, no performing without storming.

The truth of that is borne out by anecdotal accounts of groups that have managed to avoid angst by keeping in their professional comfort zones. It gives me no pleasure to report this, but it seems that some GPs are notorious for this kind of behaviour. To be fair, most GPs I have worked with have behaved impeccably, but the mythology of EBM workshop facilitation (there is such a thing — mythology and EBM in the same sentence is not a paradox) is full of dark stories about GPs using their group skills to hijack the group from the hapless facilitators. They divert the agenda away from anything involving mathematics, and self-righteously proclaim that 'we treat people, not statistics'. Senior clinicians, academics, and managers can also effectively subvert groups by asserting that they've been doing this sort of stuff for years, and know it all anyway. This is done with such self-confidence that even experienced facilitators may find it difficult to persuade them that there is anything new to learn.

Even if such flawed groups don't learn anything new, they may have a pleasant week discussing things they think they already know about, and then leave happy, reassured that there's nothing much to EBM. Of course, you get the occasional whiner who complains that he or she came to be taught EBM and the facilitators were useless because they didn't do much teaching. What such people fail to realise is what, within the first session or two, becomes only too horribly clear to the members of successful groups. If facilitation is successful, the idea that education is a process in which experts tell novices what they need to know and then set them exams on it is banished as comprehensively as pre-Galilean cosmology. Since professions have traditionally maintained their power and status by controlling professional training in exactly that way, it is hardly surprising that the reality of self-directed learning can come as a shock, and is not to everyone's taste. *Eppur si muove**.

Groups of up to three pairs of facilitators meet up regularly during workshops in 'buddy groups' to reflect on the group learning process. A regular theme by day 2 or 3 is the anxiety that 'they haven't got it yet'. As far as I can tell, a group or individual 'gets it' when they: (a) develop confidence in asking focused questions; (b) learn that scientific papers are neither holy writ nor impenetrable (and that if they are truly impenetrable they are not much use and can be junked!); and (c) begin to lose their fear of statistics. Once this has happened there are moments of pure joy when participants cross the barrier of numerophobia and merrily calculate NNTs, confidence intervals or (often for the first time) really understand sensitivity, specificity, and likelihood ratios. Or there are those who, having behaved at first like rabbits caught in a car's headlamps, lead wonderful, polished learning sessions, and are surprised and delighted to find themselves so talented.

So that's why we do it — for the moments of joy when the pennies drop, the diffident become leaders and we wonder how it worked out OK again.

Toby Lipman

*After Galileo, under pressure from the church, had recanted his claim in 1632 that the Earth moved round the Sun, and was therefore not at the centre of the universe, he is said to have murmured '*Eppur si muove ...*' — 'and yet it moves ...'.

Master classes in primary care research no. 5: patient participation and ethical considerations
Edited by Yvonne Carter, Sara Shaw and C Thomas
RCGP, 2000
PB, £16.20, 0 85084 264 6

PATIENT participation in clinical research has too often been taken for granted by researchers who have assumed that a duty existed for patients to volunteer for clinical trials, although patients may receive no benefit themselves from participating and the possibility exists that they may actually suffer harm. However, there is growing awareness of the ethical problems engendered by medical research and the stated aim of this masterclass is to examine these issues in primary care research from a patient perspective. I suspect it may also be designed as an awareness-raising exercise for many of those involved in such scientific enquiry. Frequently otherwise scientifically valid research is rejected because scant attention appears to have been given to the ethical considerations of such research. All too often, the patient information provided and the consent form appear to have been hurriedly prepared and poorly translated from a foreign language. Researchers appear to have poor understanding of legal and ethical concepts, such as confidentiality and what constitutes adequate disclosure of information to ensure validity of the consent process. It is noted that the latter is particularly difficult to achieve in primary care, where the investigator is often the potential subject's GP, making a decision to participate less likely to be truly free. Interestingly, it has become standard practice in trials sponsored by the pharmaceutical industry to declare that the doctor will be reimbursed for their involvement, but the advice here stops short of suggesting that patients should be made aware of the extent of the financial benefit to their doctor.

The contributions include several examples of 'best practice', that do not merely pay lip service to the concept of patient involvement. Importantly, these cover advice on dealing with potentially vulnerable groups, such as children, or where the capacity to consent may be impaired or fluctuating. Organisations such as CERES have already made a valuable contribution in this area, but there is little doubt that such resources deserve wider publicity, as many researchers still appear to be ignorant of their existence. Apart from helping investigators to fulfil their ethical obligations, the masterclass also makes it clear that there are many pragmatic benefits to be gained from patient involvement in the research process. I would suggest that this book provides a readable and comprehensive resource for members of local research ethics committees, multi-centre research ethics committees, and for all those either contemplating or already involved in research.

Niall Cameron

roger neighbour - behind the lines

On poetry

WITH the possible exception of Henry 'Naming of parts' Reed, I don't really do poetry. When I am informed by the late Lord Tennyson that ' "Tirra lirra" by the river Sang Sir Lancelot', none of the rejoinders which spring to my lips reflect well on either knight or poet, nor indeed on my own Plebeian self. I relate more to Nigel 'the curse of st custards' Molesworth, who, compelled to recite aloud, records the ensuing artistic treat thus:[1]

SIR THE BURIAL SIR OF SIR JOHN MOORE SIR AT CORUNNA SIR
(A titter from 2B they are wet and i will tuough them up after.)
Notadrumwasheardnotafuneralnote
shut up peason larffing
As his corse
As his corse
what is a corse sir? Gosh is it
to the rampart we carried
(whisper you did not kno your voice was so lovely)
Not a soldier discharged his farewell shot.
PING!
Shut up peason i know sir he's blowing peas at me
Oer the grave where our hero we buried.

But now and again the occasional line does press some button, does jab one in the fleshy parts, does cause to flash before the mind's eye some truth which, albeit less than clearly discerned, nevertheless cries undeniably for expression. I chanced recently upon this, from T E Hulme's *Images*:

Old houses were scaffolding once and workmen whistling.

The wretched thing's persistent, won't get out of my head. 'Old houses were scaffolding once and workmen whistling': there's a medical metaphor in there somewhere, I can smell it. And while I don't do poetry, I *do* do metaphor — which is odd, because they're essentially the same thing. To a prose-monger like me, metaphor is truth with wings, and poetry just metaphor in fancy dress. Anyway, at risk of showing myself up for the unreconstructed fuddy-duddy which at heart I probably am (and which we are all destined to become), I'm driven to try and unpack Hulme's metaphor.

Is he simply saying, 'What's now old was once new'? I guess not; a poet couldn't be that blindingly obvious. 'Even the most enduring of our institutions emerged from the mud and confusion of a building site'? That perhaps comes closer. Then again — since I'm from a generation to whom age in a house suggests character and craftsmanship rather than dry rot and noisy plumbing — Hulme could be reminding us that 'what now looks out-of-date and irrelevant was once created with skill and dedication, and should be respected for it'. Is the poet warning the young not to belittle their heritage? Or the old not to laud it over the new kids on the block, nor hold their inexperience against them? Yes. And no. That's poetry for you. Ambiguous.

I look around the urban skyline of my own professional habitat. Backlit by a setting sun are silhouetted some of the structures that have given my working life a sense of place and purpose. Vocational training, which is intended to give young GPs the time — and, more importantly, the permission and the freedom — to explore their own curiosity. The Balint movement, and all the creative interest in the doctor–patient relationship and the consultation process that flowed from it. All the local variations on one fundamental architectural design, that places the resources of the individual doctor at the service of the needs of the individual patient. Old buildings these may be; but I've in my turn put up a few scaffolding poles and done a fair bit of whistling, and I'm fond of them. So while I understand that new ways of doing medicine need new homes and premises, I do wish 'development' wasn't so inescapably a euphemism for demolition.

The JCBs and ball-hammers are at work on the brown-field building site that is to become the New General Practice. And what does the architect's model promise? A patchwork estate, some of it mock Georgian, the rest a mix of the jerry-built and the *trompe l'oeil*. And who is to live in Newtown-Blair? A dwindling generation of cash-strapped, target-driven, protocol-worshipping, initiative-purged young doctors, too busy to notice where they're living and too stressed to care much.

Gosh. Maybe there's something in this poetry malarkey after all. I feel a New Year's resolution coming on: look more carefully for the poetical in practice. I might even attempt the odd line of my own. In fact, I'll start right now by reworking Hulme.

New houses are scaffolding still and builders bickering.

Reference
1. Willans G, Searle R. *The compleet Molesworth: How to be topp in English*. London: Pavilion Books, 1984.

UK Council November

Chairman and Officers of Council, Chairs of Networks and Committees
As usual, at the first meeting of the year, Council elected our Chairman and Officers of Council and chairs of committees and networks. As you will see from the attached list of the appointments, we have now merged Publishing and Communications to create a new Communications and Publishing Network. Dr Mayur Lakhani will chair this network. This was also our new Chief Executive, Hilary De Lyon's, first Council meeting.

Fellowship Committee
We recently held a ballot of College Fellows to fill three places on the Fellowship Committee. The successful candidates were Dr Alastair Wright, Dr Jeremy Duncan Brown, and Dr George Shirriffs.

Annual General Meeting
Our next general meetings will be held in Bristol (as part of the Spring Symposium organised by the Severn Faculty) on 6 April 2003 and the AGM on 14 November 2003.

Shipman Inquiry
I informed Council about the latest developments regarding the College's involvement in the Shipman Inquiry. The Inquiry has now embarked on Phase 2 of its enquiry, which will include a series of seminars to be held in January and I will be attending one of these on behalf of the College. The areas being covered in this phase are: monitoring, complaints and discipline, whistle-blowing, and single-handed practice. I would welcome any useful information that you might have, to be included in the information we are providing. We shall be looking at the information we are to submit at the December CEC meeting before it is sent on to the Inquiry.

The Inquiry has also issued a consultation document exploring the development of a new system of death and cremation certification.

Unfinished Business: Draft Response to the Consultation Document on Proposals for Reform of the Senior House Officer Grade
Council considered the final draft of our response to this document. Apologies to all those faculties who did not have the chance to discuss the draft before Council met, but you will appreciate that considerable work was needed in putting this draft together. Overall, Council was happy with the draft and the main issues we have highlighted. The main themes we are stressing are:

- The document gives scant regard to general practice. It is mentioned approvingly as a venue for teaching and experience gathering for doctors intending a career in hospital medicine — but without exploration of the costs and implications for general practice.
- The introduction of a two-year Foundation programme must not be used to reduce the period for specialist training for general practice. Current College policy for specialist general practice training is five years.
- There should be real equivalence between general practice and other specialties, not least in the implementation of this review.
- The College gives strong support for the introduction of competency-based rather than time-based training and assessment.

The College's response has been placed on our website and can be found at **http://www.rcgp.org.uk/rcgp/education/proposals_for_reform_sho_.asp**

Postgraduate Medical Education and Training Board (PMETB)
Professor Steve Field updated Council on developments with the PMETB. Steve sits on one of the steering groups looking at training issues. Dame Lesley Southgate is a member of the steering group on assessment and also gave a briefing on how the implementation of the PMETB is progressing. The Board of the PMETB will be established in October 2003 by the Secretary of State. A consultation is currently taking place on the PMETB Regulations.

National Collaborating Centre for Primary Care (NCC-PC)
We discussed a paper from Dr Mayur Lakhani, who chairs the Board of the NCC-PC. One of the major areas of concern that came out of the discussions was the need to ensure that when guidelines are produced they are actually implemented. A paper is being developed to look at the issue of these NICE guidelines not receiving recognition in the academic Research Assessment Exercise (RAE). There is also a need to consider how the guidelines that exist in the

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four home countries are co-ordinated effectively. Mayur Lakhani will also push for the development of guidelines focusing on co-morbidity.

European Definition of General Practice
We had an interesting discussion on how the European Definition of General Practice, from WONCA, could be used and disseminated by the College. To help spread the European Definition, Dr Justin Allen has kindly shared two PowerPoint presentations with us for use in explaining what it means. If you would like an electronic copy of the of the presentations, please contact **mwhelan@rcgp.org.uk** who will be glad to send them to you.

Child Protection
You will recall, that Council discussed at its September meeting, the draft College position paper on child protection written by Professor Yvonne Carter and Dr Michael Bannon. The document has now been finalised and approved and will be available on the College website shortly. The document will be co-badged with the Royal College of Paediatrics and Child Health, the National Society for the Prevention of Cruelty to Children, the British Association of Medical Managers, and the NHS Confederation. We also plan to publish the document as a College position statement and also on our website.

Domestic Violence in Families with Children
Council considered draft guidance for primary healthcare professionals on the issue of domestic violence and the implications for children in these circumstances. The guidance, written by Dr Judy Shakespeare and Lesley Davidson of the National Perinatal Epidemiology Unit and was enthusiastically supported. The document was endorsed by Council and will soon be appearing on our website.

Council will next meet on Saturday 25 January 2003, 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 covered at Council then please do not hesitate to contact me via email at **honsec@rcgp.org.uk**

Maureen Baker

neville goodman

Targets

JUST 25% of hospitals are reaching the target for treating heart attacks. There is only one conclusion. Hospitals are failing heart attack victims. Clearly the doctors are rubbish and coronary care nurses are too busy seeing to their nail varnish. The Royal College of Physicians have painted an 'alarming picture'. The country's 'heart tsar', Dr Roger Boyle, reckons this audit has provided hospitals with the information they need to meet the standards. According to my sources, the heart tsar was appointed after long and rigorous interviews. Many cardiologists were considered, asked to submit their solutions to the UK's 'number one killer', and these solutions were pondered long and hard by a multidisciplinary team. Nothing less would do in this age of accountability. Except that apparently the appointee just happened to find himself on a train from the North East one day with Alan Milburn, who sort of liked the cut of the chap's jib, and appointed him. While the rest of us struggle with Equal Opportunity forms and rigorously conducted interviews after which all notes are stored for 12 months in case of complaint, the ministers just pick a buddy or two.[1]

How do we judge people who set standards by which to judge a workforce? My conclusion from the RCP's audit is that the standards were set far too high. Those who wrote the NSF for coronary disease need to rethink their target of 30 minutes to thrombolysis, and Roger Boyle should be apologising to the hundreds of staff who are now feeling victimised and demoralised. Targets must be set bearing local circumstances in mind; national targets are an abstraction. This is not the first NSF to fail so spectacularly, and I wonder how many were actually trialed after the great and the good sat around their tables laying them down. As a rule of thumb, any target failed by more than 20% is unrealistic and has been set by people who should have done their homework better.

I wonder what targets Jean-Pierre Garnier has been set? He is chief executive of GlaxoSmithKline, one of the biggest of Big Pharma, and it is in trouble. Its profits and share price are down; its R&D faltering. M. Garnier earned £7 million last year, but says he needs more money to keep him motivated. He wants one million share options (worth £12.5 million) plus 200 000 free shares. Yes, I know there are footballers and pop stars who earn more, but something about Jean-Pierre makes me despair of humankind.

Nev.W.Goodman@bris.ac.uk

Reference
1. Cohen N. 'Just like his pal Silvio'. *New Statesman* 18 November 2002; 26-27.

our contributors

David Beales lives near Cirencester, Gloucestershire. He has published widely, famously (with Nethercott) on the effects on health of closing a sausage factory
Niall Cameron, newly M Phil'd, has enlivened Bearsden dinner parties with ethical quandaries for years now ... He practises in Govan, Glasgow
Namir Damluji is currently Associate Clincial Professor of Psychiatry at the University of California, San Diego, California. Previously he was a full time faculty member at the American University of Beirut Department of Psychiatry from 1997–2000, and in 2000 was the chairman of the department
Amanda Howe chairs the RCGP Research Group. She is Professor of Primary Care at the School of Medicine, Health Policy & Practice, University of East Anglia
amanda.howe@uea.ac.uk
Najla Lakkis is chief resident, Department of Family Medicine, American University of Beirut.
Toby Lipman is a GP in Newcastle. He can write a book review on almost anything in about fifteen minutes
Orest Mulka practises in Leicester. He is the RCGP Ukrainian Fellow and author of the first ever textbook on general practice written in Ukrainian
Roger Neighbour recently delivered the 21st George Swift Lecture to the RCGP Wessex Faculty — full text at
http://www.rcgp.org.uk/rcgp/faculties/wessex/Swiftlecture2002.doc
Shmuel Reis as well as his wife were born to Holocaust survivors. The Holocaust is ever present in their families. (Department of Medical Education, Rappaport Faculty of Medicine, Bat Galim, Haifa, 31096, Israel. **reis@netvision.net.il**)
Bassem Roberto Saab MD is Associate Professor in the Department of Family Medicine, American University of Beirut, P.O. Box 113 – 6044, American University of Beirut
brsaab@aub.edu.lb
Graham Smith is a social historian now based in Sheffield. His work on Paisley doctors was carried out with Graham Watt and Malcolm Nicolson at the University of Glasgow
Tomas Spenser was rescued from the Holocaust at the age of 11 by a 'Children's Transport'. His mother was gassed at Auschwitz; his father survived Auschwitz and died later. He qualified in St Andrews in 1950. Since 1966 he has lived in Israel, practicing and teaching as a rural GP until his retirement.
Shaun Treweek has acquired a PhD and is presently working in Oslo
Shaun.Treweek@shdir.no
Jinan Usta is a Clinical Assistant Professor, Department of Family Medicine, American University of Beirut

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

saul miller

Time to toe the line

We are in the midst of a national advertising campaign about athlete's foot. No, really, it's true: check your daily paper. Somewhere in there, between the early pages that major on adverts for cars, mortgages, and computers, and the later pages that carry promotions for corsets and other devices for those tired of cars, mortgages and computers, there will be one about corporal fungus. Not selling it of course. Rather, a public service advertisement, warning darkly of the dangers of being a carrier. To be fair, the version I keep coming across doesn't actually spell out the dangers but it implies them well enough as it alludes to the guilt I must feel should I turn out to be a Carrier Who Didn't Seek Treatment.

Well, luckily I have the opportunity to confess here and now: I am a Carrier Who Didn't Seek Treatment. Nor have I sought help yet. Recalcitrant is the word to describe my shameful behaviour. But then, wait till you hear who is sponsoring the not-for-profit organisation that cares so deeply about my spore-ful infectiousness: a business that makes and sells treatments for all manner of fungal afflictions. A symbiotic relationship perhaps? How fortunate are such arrangements!

My imagination is stirred, as I take a pause from reading the lesser domestic news, by the idea of a person (surely it can't be a whole team) dedicating an entire career to the pursuit of the war on fungus. Perhaps because it must take such a caring attitude and yet so much energy, I imagine this person as a woman, young and ambitious. I am intrigued with the concept of what life must have been like for her, setting up a radical single issue campaign organisation like that when all her friends, themselves still with the time to meet up at coffee shops and chat, must have thought her mad. Did she have a partner? Was he supportive or was he another who believed athlete's foot should be brushed under the carpet?

Imagine her struggle to make an impact from some sweaty armpit of a backroom office. All those letters of rejection from the many magazine editors to whom she submitted her proposal for a regular column. The family-friendly events she thought up along the way to raise the profile of her work but to which no-one came: the Dermatophyte Derby and the Thrash Thrush Yoghurt Meet perhaps. And all along her parents still hoping to persuade her back towards the career in horticulture that had at one time appeared to be mushrooming.

How did this person endure those years without any public recognition for her efforts? It must take a strong woman to pursue such an apparently hopeless cause as that for so long without once faltering. Think too of the personal setbacks: finding that even she, with her scrupulous hygiene, could harbour such evil germs from time to time must have been hard to swallow.

Against this background of struggle and rejection she won through, however. She managed to convince a large multinational of the purity of her struggle and, indeed, of their joint interest. For the first time someone listened. How glad must have been her heart when they first agreed to fund a major advertising campaign to highlight her organisation, her message!

Now, reflecting like this as I turn the pages on towards the foreign news, I feel fortunate that this person chose to stay in Britain, to fight her fight here, to benefit us. I feel rueful for all this time I have been harbouring the very germs she has dedicated her existence to fighting. I promise myself I will go for treatment at last. More, I will seek out all my mouldy patients and persuade them of the true way.

That I ever hesitated, thinking of the adverts as a cynical ploy by the drug company to stoke demand for its products, seems itself so shameful now.