

The Back Pages

viewpoint

Videotapes for summative assessment and MRCGP need abolishing

THE former convenor of panel of examiners for the MRCGP examination now admits to wondering whether 'we aren't in danger of elevating the consultation process to something rather more sophisticated than it is good for'.¹ Well he is big enough to admit 'honest hypocrisy' but, in my opinion, this turnaround has come too late for the good of summative assessment and the video component of the MRCGP examination.

Some years ago I attended one of Roger Neighbour's study days and came away with several useful techniques to use in the consultation. I now encourage my registrars to consider adopting his 'inner consultation' model as I think it is very practical and user friendly. I use the comparison of the new registrar developing their consultation skills with that of a beginner at golf. We professionals check that their grip, stance, set-up, and aim are correct. We then analyse their swing and make helpful suggestions. We go out on the course with them once a week in our joint surgery. This is formative assessment.

However, at the end of the year summative assessment should involve seeing where the ball is actually going and how they are really scoring. Instead, analysis of the individual parts of the swing is assessed and a completely false impression of their consultation skills is obtained.

Since becoming a trainer, I have been involved in helping registrars prepare videotapes for summative assessment and the MRCGP examination. I am appalled and depressed on the effect this is having on an already cluttered and brief year. I am afraid the finger needs firmly pointing at those professional bodies who must take responsibility for what I can only describe as a fiasco. Well meaning intentions have metamorphosed into an ugly reality.

The College attempts to make the process seem relatively painless and straightforward,² but I know the reality is far from true. The conscientious registrar has paid a considerable sum of money to enter the exam and of course does not want to fail. Consequently, an inordinate amount of time is spent in trying to get everything right. Prompt lists regarding performance criteria are pinned on to walls as *aide-mémoires* and the right case-mix of patients is sought. The final result is 'consultation by numbers'. It is artificial, bearing little resemblance to real life. At a time when registrars should be gaining momentum and trying to consult at realistic intervals, the converse results in this search for perfection. To add insult to injury, further time is spent editing and refining the final product. My last three registrars and I have gone through this exercise and we have all become thoroughly demoralised by it. I am delighted that they all passed but what ultimately did the process test? We are trying to produce GPs who can consult and communicate effectively, face to face, and spontaneously, with their patients. In my view, the simulated surgery remains the gold standard and sufficient resources should be made available to carry this forward. If this is not financially possible then perhaps an objective structured clinical examination (OSCE) could be designed that could effectively assess consultation skills, but not require so many simulated live patients.

Please let common sense prevail and, if we are to assess our future GPs' consultation skills, let us do it realistically. I agree it is disappointing that registrars demonstrate only limited ability in achieving a patient-centred approach.³ However, we live in the real world and sometimes patients actually quite like their doctor advising them as to what to do for the best. My current registrar told me this week of a patient who had been videotaped in one of my previous registrar's surgeries. The patient apparently started this consultation by saying 'Please don't ask me what I think is wrong with me or ask me what you think I should do. Just talk to me and let me know what you think, in your opinion, is best for me.'

When all is said and done, doesn't that sound perfectly reasonable?

Mike Cohen

References

1. Neighbour R. On consultation skills. *Br J Gen Pract* 2002; **52**: 965.
2. Tate P. Consultation skills assessment by videotape. In: Moore R (ed). *The MRCGP Examination*. 4th edition. London: RCGP Publications, 2000; 58-82.
3. Champion P, Foulkes J, Neighbour R, Tate P. Patient-centredness in the MRCGP video examination: analysis of a large cohort. *BMJ* 2002; **325**: 691-692.

"You know, we have one patient — I think he's dead now — but I mean he was a bronze medallist in the 1924 Olympic steeplechase. Now that's no relevance really to his medical history but it's a nice wee thing to know about the person."

Patients' records, Paisley docs, Elizabeth Mitchell, Graham Smith, page 163

contents

164	news Hilary De Lyon
165	flora medica ... the November journals
166	paisley docs 9 Record keeping Elizabeth Mitchell, Graham Smith
168	essay End-stage social pathology Peter Davies, Seth Jenkinson, and Trefor Roscoe on empathy
170	digest and reflection James Willis on complexity, Liam Farrell on <i>The Two Towers</i> , and <i>neighbour</i> behind the lines
172	Philippa Whitford recalls Gaza, goodman on Joe Strummer plus diary
174	Our contributors and munro on Platonic driving

College response to the Crisis report — homeless people's access to GPs

THERE are many GPs working hard to make primary care equitable. Although the survey commissioned by Crisis is a very small sample — only 104 GPs — the RCGP does acknowledge the fact that not all surgeries are aware that homeless people can register without an address. We agree with Crisis that more primary care workers need to know that anyone who doesn't have a home address can quite legitimately register by using the surgery's address instead.

However, it is important to point out that many doctors are not taking on new patients, with or without an address, because there is a major GP workforce crisis. The RCGP has made it clear to the government that we need 10 000 more GPs in order to provide all patients with the care they deserve. The Crisis report does not take the chronic shortage of GPs into consideration.

In the 2002 *RCGP Statement on Homelessness in Primary Care*, we recommended that primary care practitioners should provide a welcoming and sensitive service to homeless people and enable them to access the full range of health services required to meet their needs. We also recommended that homeless people should be registered permanently wherever possible and integrated into all health prevention and promotion activity within the practice.

Maureen Baker

This statement was sent to all Primary Care Organisations in the UK and to the Department of Health.

http://www.rcgp.org.uk/rcgp/clinspec/hin_eqgr2.asp

New audit tool to help manage patients who have had a heart attack

AN audit toolkit to help primary care staff set up local protocols for the long-term management of patients who have suffered a heart attack has been published by the National Institute for Clinical Excellence (NICE) in association with the National Collaborating Centre for Primary Care (NCC-PC).

The aim of *Audit of the management of post-MI patients in primary care* is to help teams working in primary care to plan and perform meaningful audits of their management of post-myocardial infarction patients. Options for data collection are included to take into account the varying data systems used in healthcare teams.

The audit advice covers drug treatment, lifestyle advice, and referral for cardiac rehabilitation. It also includes review criteria, guidance on conducting an audit, and information about other sources of advice.

All those who are at high risk of, or with established, coronary heart disease should be able to be identified by the primary care team and included on a CHD management system within their practice.

Coronary heart disease is the single most common cause of premature death in the UK, with 300 000 people suffering heart attacks every year. By taking a more systematic approach to monitoring and intervention within a primary care setting, these numbers have a chance of being reduced.

The project was led by Professor Richard Baker, Director of Clinical Governance R&D Unit, Department of General Practice and Primary Care at the University of Leicester.

Fifteen practices in Wales piloted the review criteria and the data collection instruments, providing feedback on the feasibility and acceptability of the advice and describing any implementation issues or difficulties they encountered.

Audit of the management of post-MI patients in primary care can be downloaded from the NICE website at <http://www.nice.org.uk/cat.asp?c=38482>.

From the journals, December 2002 ...

Introducing Hilary...

I joined the College as Chief Executive in November 2002, having undertaken the same role for the Society of Chiropractors and Podiatrists for almost four years. Following my appointment in August, my initial priorities have been to understand the work of the College, the varying roles, interests and views of members and, more broadly, to learn about general practice and the education of GPs.

Before joining the College and during my first few weeks I have been asking members, as well as those who have chosen not to join, about how they see the College. My initial impression is that, while the College undertakes a huge range of activities, it can feel a rather remote and academic organisation, which does not always understand the needs of ordinary members, and has not been good at communicating effectively with members. We are keen to address these issues.

The Chairman, David Haslam, is a practising GP, who understands very well the demands of life in the NHS. We are trying new ways of communicating with you, such as an e-mail newsletter, and a quarterly journal, *The New Generalist*, which will replace the annual Members' Reference Book. We are also redesigning the annual report and our website. In addition, we are undertaking a review of our activities, in order to ensure that we are fulfilling our aims in the most effective way. We will be reporting to you on the outcome of this review later in the year.

Devolution has important implications for the College, as it does for all organisations that cover the whole of the UK. It is important that I learn about the membership and the work of the College across all four UK countries. I have therefore been visiting GP practices, attending College conferences, lectures and meetings in Scotland, Wales, Northern Ireland and England.

I shall be continuing my programme of visits in the coming weeks and months. I look forward to meeting as many members as possible during the course of my visits, and to hearing your views.

We are here to promote and support you in the difficult and demanding role you perform for the community. Please help us to do this as effectively as possible by giving us your views on both the College's activities and better communication with you. You can email me at chiefexecutive@rcgp.org.uk.

Hilary De Lyon

N Engl J Med Vol 347

1825 The AFFIRM trial fails to affirm the idea that you can abolish the risks associated with atrial fibrillation by cardioversion. In fact this study shows slightly worse event rates in atrial fibrillation treated by rhythm conversion, as opposed to rate control and anticoagulation.

1834 And that is what a European study also shows.

1909 Single-dose chickenpox vaccination failed to prevent a chickenpox outbreak in a US nursery.

1924 Reconnecting severed legs usually produces no functional benefit in the long hop.

1941 Encouraging people with intermittent claudication to exercise improves their walking distance and their general health.

1999 A powerful predictor of outcome in breast cancer — a gene-expression signature combining 70 genes.

2046 A useful and detailed review of herbal remedies and their evidence base.

2104 Don't give any kind of NSAID to a patient who has ever had a bleeding ulcer, is the message of this study comparing celecoxib and diclofenac-with-omeprazole in patients without *H. pylori*. Excellent discussion on page 2162.

Lancet Vol 360

1803 Another landmark study of post-coital contraception from the WHO shows that you don't need two separate doses of levonorgestrel — a single 1.5 mg dose taken in the first five days will prevent conception.

1831 Why are some strains of influenza so deadly? Probably because they trigger chain-reaction production of TNF-alpha.

1840 Sunshine causes a sunny disposition by increasing serotonin metabolism.

1851 Reluctant to prescribe hormone replacement therapy and wondering what to do for hot flushes? Go to this good review.

1903 The lower your blood pressure the better, according to this analysis of data from one million adults, which failed to find any threshold.

2009 Ultrasound is dependable for picking up congenital hip dysplasia.

2026 Dying with dignity is studied in two Canadian centres — with optimistic results.

2047 They've added folic acid to flour in Canada — and reduced neural tube defects dramatically.

JAMA Vol 288

2701 A UK randomised trial of a structured interview of women wanting to know options for treating menorrhagia. Those interviewed had fewer hysterectomies, saving costs.

2724 Fascinated by the possible link between *Chlamydia pneumoniae* and cardiovascular disease? Here's the review you need, though it remains inconclusive.

2868 Wondering how to get your patients to take their medicines? Here's the review you need, though it too remains inconclusive.

2981 Most hypertension trials have shown that event reduction is related purely to blood pressure reduction rather than to drug class, but following ALLHAT this may be old hat. Low-dose thiazide diuretics are the surprise winners in competition with ACE inhibitors and calcium channel blockers.

3019 And ALLHAT also shows no benefit from a statin if blood pressure is controlled and LDL-cholesterol only mildly raised.

Other Journals

Arch Intern Med **162**: 2527 reviews the evidence and confirms that corticosteroids help in acute exacerbations of chronic obstructive pulmonary disease. *Ann Intern Med* **137**: 875 finds that accelerated bone mineral loss occurs after withdrawal of oestrogen in postmenopausal women, but not after alendronate; and excessive anticoagulation with warfarin can now be reversed instantly using human recombinant factor VIIa (page 884). An outbreak of smallpox in the USA, in Boston (1901-1903) is revisited on page 993: the mortality was 17.5% and all deaths occurred within 18 days.

A Dutch study in *Neurology* **59**: 1915 looks at the influence of various kinds of fat intake and dementia — there is none. In *Arch Dis Child* **87**: 530 the records of children with UTIs are found to contain more preceding episodes of unexplained fever than controls, but there is no evidence that delayed diagnosis led to renal scarring.

Further round the globe, the *Ann Coll Surg Hong Kong* **6**: 109 examines the idea that retrocaecal or retroileal appendicitis is more easily missed, and finds that it isn't. While in mainland China, a new terror rears its head: long-term infection with *Helicobacter pylori* in Mongolian gerbils (*Chin J of Dig Dis* **3**: 115). They claim they will be used for research rather than in bioterrorist attacks on junior schools in the West.

Plant of the Month: *Petasites fragrans*

An invasive weed worth forgiving for two reasons: its intensely heliotrope-scented flowers in the bleakest wintertime, and its value as a remedy for hay fever.



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

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

References

1. Even promisingly titled papers are disappointing in this area. See, for example, Gill GM. Chaos in A4 records in general practice. *Health Bull* 1981; **39** (3):153-156 — a paper that has more to say about shelf sizes than the understanding and use of records.
2. Roland M, Holden J, Campbell S. *Quality assessment for general practice: supporting clinical governance in primary care groups*. Manchester: National Primary Care Research & Development Centre, 1999.
3. Such claims have been made by both GPs in the Paisley study, funded by the Wellcome Trust's History of Medicine programme and in the earlier study, *The Oral History of General Practice in Britain, c. 1935-1952*. Also funded by Wellcome, the recordings are archived at the British Library's National Sound Archive.
4. GPP 25.
5. One practitioner claimed that he knew of 'practices who have kept family folders' (GPP 30).
6. Mitchell ED, Sullivan FM. Chapter 8: Information technology in primary care. In: Sims J (ed). *Primary Health Care Sciences: a reader*. London: Whurr, 1999.
7. Berger J. *A fortunate man: the story of a country doctor*. London: Allen Lane the Penguin Press, 1967, p. 109.
8. Smith G. An oral history of everyday general practice 8: Patients and populations. *Br J Gen Pract* 2003; **53**: 76-77.
9. GPP 25.
10. GPP 08.
11. GPP 12, see GPP 07, GPP 09 and GPP 22 for very similar accounts.
12. GPP 09.
13. GPP 22.
14. GPP 24.
15. GPP 28.
16. GPP 09.

An oral history of general practice 9: Record keepers

WHILE the technical aspects of record keeping have attracted much attention, the social and historical contexts have been neglected.¹ Little has been written on the impact of record keeping innovations on everyday practice, or on the relationship between the information that is recorded and details that are remembered.

A definitive report on quality assessment in general practice, states that primary care records are 'more than an *aide-mémoire* to the doctor or nurse'; indeed, good quality record keeping is regarded as an 'essential aspect of care'. In addition, during the past two decades, practices have had to demonstrate high standards in record keeping as a condition of training practice accreditation.² However, this has not always been the case, and the record serves a multiplicity of functions, which continue to vary between practices both in degree and use.

Doctors who began in practice before 1948 have claimed that they made little use of records and relied on their memories for patient care.³ It was only with the development of educational initiatives, mainly by the RCGP, that the importance of record keeping in longitudinal care became more widely accepted by practitioners. Even if GPs had been convinced of the need to keep more detailed records — and most were not — there was little in the way of infrastructure in practices for storing and maintaining large volumes of paper records.

By the 1950s, records were still infrequently referred to, but were more likely to be used to monitor the workload of individual partners, especially regarding house calls. A decade later, however, some practices were adopting new approaches to record keeping, linked to attempts to persuade senior partners to abandon strict adherence to individual patient lists. Yet, the pace of change was uneven and as late as the 1980s some practices in Paisley continued to keep patient records in ways that would have been recognisable to practitioners in the 1930s. One GP, for example, recalled an older partner making the joke that, 'Someday we'll get those files out and find out what's wrong with the patients'. The files were only taken out when a younger partner, with a general practice training, joined the partnership in 1982.⁴

Although use of the A4 record was trialed in the late 1960s and was suggested as a replacement for the Lloyd George envelope in both 1974 and 1977, plans to introduce it as the standard throughout the UK were never fulfilled. In 1983, however, it was offered to practices in Scotland. In the Paisley study, A4 records were identified by older working, and recently retired, GPs as a key change in the history of general practice. These GPs were responsible, and often took part in, transferring patient records from

Lloyd George envelopes to A4 folders. This they believed, added significantly to their understanding of individual patients.

The testimonies suggest that there are differences in the ways Paisley's GPs have used A4 records. Even with the possibility for greater completeness that the A4 record system affords, most of Paisley's working GPs are aware that they continue to rely a great deal upon their own memories and that of colleagues, particularly in recalling community and kin relationships.⁵

Electronic record keeping had emerged in parallel with manual systems, but its use in general practice only became more widespread in the 1980s. The 1990 contract emphasised patient targeting and disease prevention, linked remuneration to practice activity and, as a result, encouraged further adoption of electronic records. Not only did practices need to identify groups of patients by age and sex, they now also had to identify them by disease. Categorising and identifying patients in this way is quicker and easier with a computer and this, together with the Department of Health's offer of 50% reimbursement on costs, led to an increase in the number of computerised practices, from around 30% in 1989 to over 60% in 1991.⁶

Paper records, according to Paisley's younger practitioners, remain useful for a number of reasons. Some believe that paper-based recording has increased in the 1990s as a result of fears of patient litigation. Others highlight the deficiencies of electronic recording and argue that paper records complement the doctor's memory of patients (often and somewhat ironically referred to as a 'database'). Longitudinal care encourages memories of individual patients to be rearranged, or retranscribed, over time, while the paper record builds layer upon layer with each medical encounter. In addition, handwritten paper records can provide the practitioner with opportunities to recall consultations and patients with a detail and depth that electronic recording has yet to match. Not only do paper records allow for uncertainty and speculation in ways that electronic coding systems do not, but re-reading handwritten records also offers the possibility of recalling the context of particular consultations, including the state of mind of the practitioner.

More than 30 years ago the role of the GP was described as a 'clerk' of a community's 'records' who 'represents them' and 'becomes their objective (as opposed to subjective) memory'.⁷ In the intervening period there have been fundamental changes in the doctor-patient relationship⁸ and practitioners are now much less likely to take such a central part in the populations they serve. However, whether aided by paper or electronic record keeping systems, doctors' memories of patients and their social contexts remain significant to patient care.

The oral evidence

Andrew K: 'We had Lloyd George and we kept them in cabinets ... now these were our receptionists' ... pride and joy and not taken out at any time. They were stored, everything was stored there, but we never used the files. The files were not brought out for us to use. So I didn't have [as a new doctor in the practice] any knowledge of the patients coming to see me. The patients would come with all their bottles, with all the medication, and say, "Doctor, that is what I'm getting", and I would just write out what the medication was. But we never got the files out. The partners' attitude at the time was, "Well we know the patients, we don't need files, we, I've known them all their life ... why would I want to write anything down?" ... We kept the letters that came in from the hospitals in a pile, which just got bigger and bigger...'9

Many doctors who entered practice before the 1950s did not take record keeping as seriously as subsequent generations would.

Donald W: 'Records are a very useful tool ... how you previously treated people, whether it worked ... When I joined this practice [c. 1964] there were two other doctors ... and they both had their records in their rooms. It took me a couple of years, but I got them all amalgamated ... It was a very personal list system ... If you've got records you actually know that these are your patients, because before people used to walk in the door and you didn't have records for them, but you treated them. [Before] they didn't know that they weren't your patients ...'9

By the end of the 1980s most Paisley practices either already used or were engaged in converting to A4 records.

Carol S: 'We moved [premises] in March '87 ... We took hundreds [of records] home. Months and months. I did most of them. About that time about five or six thousand [short pause] ... It was hard work and it had to be done and it's important to do it; good records make a huge difference. But it was very tiring doing it all yourself. They were transferred immediately but then they had to be summarised. You know they would have been in the Lloyd George envelope so they would have been, we put them into their new envelopes, filed them, but then we systematically had to go through every single one and summarise it.'10

Eleanor H: 'I mean we spent weekends [in 1982] transferring notes and the whole team

was involved, you know receptionists, practice manager, and partners. We just all came down over several weekends and just transferred all the data ... and of course it wasn't just a question of transferring the notes we had to get shelves built and re-organise the storage space.'11

Standards in record keeping were enforced through postgraduate education.

David D: 'I'm not sure to what extent other partners felt that they had their notes up to date but I don't think even they were feeling that they were 100%. So I think we were given a year to get ourselves sorted out before we were knocked back completely, but we used that year to, to get everything up to scratch and did actually get recredited after a year but we went a year without a trainee ...'12

Some GPs are acutely aware of the limitations of records, whether paper or electronic.

Colin R: 'There's also thousands of snippets of information that we know about patients that isn't in the records — you know, who their auntie is. You know, we have one patient — I think he's dead now — but I mean he was a bronze medallist in the 1924 Olympic steeplechase. Right. Now that's of no relevance really to his medical history but it's a nice wee thing to know about the person. So that's not in the summary but that might be in his records somewhere. You know, one of us will have written it in. I wrote in about one patient, "She traced her family back to the Spanish Armada" ... That's general practice as opposed to the bald facts — diabetic, thyrotoxic, hypertension. So the computer doesn't tell you the whole story ...

'Well you see the other thing is you store [in memory] lots of information about patients which comes from extraneous sources ... You know you store it in your head and it's not written down. I mean I suppose if you were to write everything down the records would be enormous.'13

Margaret G: 'Oh well that doesn't go into any envelope or A4 or anything else. That only comes with growing up with the practice and is invaluable. But you can't hand that down to somebody. You see if a man of twenty has had indigestion, well you have to look into it, but if you know that his grandfather died in their house with cancer of the stomach, well there is no way that can be written down on his [the young man's]

case sheet to tell a stranger [pause].

'But if you know that you can think maybe he has indigestion from something, maybe he is worrying that he has cancer like his grandfather had. Ehem, when very often that was the case and if it's brought up then he is reassured [and] the indigestion got better ... A man dies of cancer of the stomach you're not going to put [that] into a grandson's sheet ... and that is where the family doctor comes in.'14

Other doctors point to the idiosyncratic aspects of record keeping.

Fiona T: 'In the time it takes from calling them [patients] to getting them through I have at least scanned quickly through their summary sheets, their last consultations, their drugs and their hospital correspondence ... I make notes ... they may have told me about employment or something like that; things that, that build up a picture of them as a person. I also make notes about my plans for their management ... I have got a way of putting that down within the written notes that reminds me the next time ... that was what I was going to do, but I may not have told them. Or if it [the note] is in a different place I will have discussed it ... Other partners may not understand my systems. It's my system [laughs].

'It's one of the reasons that I am nervous about the concept of a paperless practice, although not negative about it. But anxious that, you lose that subtlety of where you wrote it, or how you wrote it. What size you wrote [laughs] I don't know ... Something they have said, you know, that you maybe want to explore a bit more ... I haven't got secret signs but definitely sort of occasionally put a wee underline or something beside it to say next time they're in, push that area a little bit further and see if they can find out what's going on. How do you do that on a computer screen?'15

David D: 'I link patients to an address. If I see them at home on a regular basis I certainly link them to an address. And, it wouldn't be the first time I'd have gone to someone's previous address ehh because I still link them to that ... I don't know that I see, "there's Mrs Stroke" or "there's ... Mrs Neurotic" ... I'll probably be able to name first and then follow on that with some aspects of their medical history ... All too often it's "nutter", you know [laughs].'16

Elizabeth Mitchell
Graham Smith

‘THE trouble with the British system of medicine is that it allows you to get one foot in the grave and then tries to pull you back out again!’ So said an anonymous foreign patient.

Proving this point, we went recently to a PCT-organised educational event on improving treatment strategies for type 2 diabetes mellitus. We spent the afternoon learning how to make the ropes stronger to pull the patients out of trouble by correct diet, losing weight, screening effectively, using insulin sensibly, and the raft of other measures that pass for treatment of type 2 diabetes mellitus. Many of those attending the meeting had a body mass index (BMI) of well over 25, and yet we were still talking about treating the patients as ‘other’.

The local diabetologist described the insulin resistance syndrome¹ and the difference between that and diabetes. It is increasingly obvious that there is no difference. The underlying pathology is insulin resistance and this starts as your activity reduces and your weight increases. Most people with a BMI over 25 are already in an unhealthy state and heading for a worse one. The terms simply describe stages on a very slippery slope; that many in our society are skidding down very quickly. If it was skiing it would be marked a black run and only daredevils would try it. In our society it has no warnings, just a glowing, neon sign marking out the fast food joint of your choice.

Waiting for the blood glucose control to get so bad that diabetes arises is daft. The damage is being done slowly and steadily and is affecting endocrine and vascular processes at the same time. As doctors we know that these pathological processes are happening. If we watched a cancer progress like this it would be high-order negligence, but because it is a consequence of a ‘bit of middle-age spread’ we delude ourselves that it is a natural process and that our job is to intervene when the diagnosis has been established.

We then spend a fortune of taxpayer’s money on hyperactive medical interventions to sort out problems that have developed over the 20 to 30 preceding years. These are easily spotted problems that in any sensible scheme would have been seen and sorted years before they reach the stage of recognisable medical diseases. We do trials such as UKPDS,² which brilliantly provide evidence on how best to manage type 2 diabetes.

We forget that fundamentally this is really describing how to elegantly shuffle the deckchairs on the Titanic. ‘Would you like a better view of the iceberg, sir? Here’s a blanket to keep off the cold.’ The GP conducts the orchestra as the patient slowly shuffles between practice nurse, dietician, chiropodist, diabetes clinic, cardiology

clinic, cardiac surgery clinic, vascular surgical clinic, optician, ophthalmologist, and nephrologist, each of whom valiantly does their bit to try to patch up the damage done. The ship is holed below the waterline and still the medical band keeps on playing.

All this medical expertise assembled to do battle with pathology. And the battle is fought too late and too expensively, long after the fight for health has been lost. Even worse, the combatants believe in what they are doing and demand extra doctors and ever more resources. The government buys into this nonsense and says it will find more resources.^{3,4} What an expensive way to slam the stable door after the horse of health has bolted!

And what an incredible way to run a health service. The assumption implicit in all this activity is that patching up illnesses is the best way to make us healthier. The medical activity is remedial at best and intrinsically cannot generate greater health, either at individual patient or community levels. While we accept the Judeo-Christian ethic of helping our fellow men and women in distress, we struggle to see the intelligence in a strategy that allows people to get ill and into distress so we can demonstrate caring when we pull them back out!

As doctors treating type 2 diabetes mellitus, (and many other chronic diseases), we find that we are managing the end stages of the toxic interactions between a patient’s beliefs, their behaviours, and their environment and the impact of these on their human biology. By providing the delusion of effective treatment we are colluding with the patient and society by treating as diseases what are really social and environmental disasters manifested within biological systems. As doctors we are treating end-stage social pathology.

Perversely, by doing this we are achieving two unintended and harmful consequences. Firstly, we are spreading a delusion to patients and politicians that says that even if people get ill it is not too bad as there is treatment available. Secondly, we are encouraging the displacement of social and environmental problems into the medical domain. This encourages people to overvalue medical expertise when what they really need, and should want to do, is to achieve health for themselves. Our own profession in this context is disempowering the public, either as individuals or collectively through representative structures, from pursuing measures and policies that would generate better health for themselves, their community, and the country. This is Illich’s medical nemesis writ large, but probably not for the reasons Illich would give.⁵

We accept that, at an individual doctor and patient level, on grounds of compassion and

References

1. Nolan JJ. What is type 2 diabetes? *Medicine* 2002; **30**: 1, 6-10.
2. Stratton IM, Adler AI, Neil HAW, et al. Epidemiological association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35). *BMJ* 2000; **321**: 405-412.
3. Robinson R. Gold for the NHS. *BMJ* 2002; **324**: 987-988.
4. Moore W. NHS to receive an extra £40 billion over next five years. *BMJ* 2002; **324**: 993.
5. Illich I. *Limits to medicine. Medical Nemesis: The expropriation of Health*. London: Marion Boyars, 1974.
6. Aristotle. *Ethics*. [Trans: Thomson JAK.] London: Penguin Classics, 1955 and 1976.
7. Davies P. *The Big Picture of Health. Caduceus* Spring 2002; **55**. (<http://www.caduceus.info/archive/55/bigpicture.htm>)
8. Anand SA. *The concern for equity in health. J Epidemiol Community Health* 2002; **56**: 485-487.
9. Persaud R. *Staying sane*. London: Bantam Books, 2001.
10. Watt G. All together now: why social deprivation matters to everyone. *BMJ* 1996; **312**: 1026-1029.

pragmatism, there is a current need for a remedial illness treatment system in our country. We accept that every day, well-intentioned individuals in practices and hospitals across the UK work hard to do their best for patients, within the constraints of the current system, and the confines of its patterns of thoughts.

However, in this essay we are looking beyond the surgery consultation to the wider drivers of illness within our society. If, as individuals or collectively, we fail to do so, then we are colluding with a system that fails the public, and creates conditions within which people are likely to become ill. Simply treating the unhealthy bodies that are the end results of an unhealthy body politic⁶ does not constitute an adequate health policy. Nor does it provide a basis for a satisfying pattern of medical practice.

Perversely, in our country we are much too quick to criticise our politicians for failing to provide resources for medical treatment, but we are strangely quiet about getting our politicians to do anything about mobilising the forces in our society likely to generate good health. So long as politicians, patients, and practitioners are content to play along with the delusion that treating end-stage social pathology is the right way to practise medicine, then medicine will simply be an expensive financial millstone on the Treasury. We really need to melt the iceberg of disease. At present we simply try to attack the tip ever more destructively, while ignoring the collateral damage to the surrounding ocean.

What we think is a health service is really an illness treatment service. The sooner this concept is understood the sooner attention can be focused on medicine as a remedial enterprise (its proper role). Health can then take its rightful place as an outcome state that is far greater than absent or well-treated disease.⁷⁻⁹ We can change positively public policy in a direction that will generate health.

We need to see all the places where we treat the end results of social pathology and act to alter the environment and the social context in such a way that the stream of patients to the illness service is reduced.¹⁰ We need to put the responsibility for treating the conditions that give rise to end-stage social pathology back into the realms of public debate and political action. We need to reinvigorate public and politicians to take the lead in debating health and to get away from the obsession with remedial illness treatment that currently masquerades as the health debate in this country. Paradoxically, perhaps only doctors can lead this change.

Peter Davies
Seth Jenkinson

trefor roscoe

Empathy

WHEN I was a teenager, I suffered from recurrent tonsillitis and a mother who felt that 'something should be done about it'. I was always being taken to the doctor because of sore throats. This and childhood asthma was my introduction to general practice and it made a lasting impression on me.

In those days the doctor and his family were part of the community they lived in and everyone knew all about them. The odd thing about this GP's family was that they were incredibly prone to sickness. I say this because of the habit the doctor had of telling his patients that a member of his family had suffered from the same complaint that they were presenting with. If one of his family had not had it last week (in the case of acute fever) then they had had it within the past few months or, if it was something rarer, some years ago.

I occasionally find myself saying to patients that I have seen a case in my family of whatever, but I try to keep this to a minimum as I remember how our GP was renowned for claiming that it ran in his family, no matter what it was. If you were an infrequent visitor, you might have believed him and felt that his empathy was helpful. However, talking to one's neighbours in the village revealed that members of this GP's family regularly had heart attacks, strokes, whooping cough, and cancer in all its forms. It eventually became a bit of a joke in our family that the doctor's wife was always ill and his family members were some of the NHS's best customers. I think that most regular visitors saw through his attempts to empathise and treated it as well meaning but amusing.

This reminiscence made me think about how we reveal ourselves to our patients. Empathising is essential and we are all aware of how we change our consultation style to fit the patient. Accent, vocabulary, and demeanour all change from one consultation to the next, and sometimes even within the same consultation. We often say about simple common ailments, such as hay fever or asthma, that we have had the same thing ourselves.

Many of us no doubt continue to use our family as examples of how to cope with minor illness. Telling patients that their symptoms are nothing to worry about because you know from personal experience that they are not is part of the essential reassurance that people seek from us. I began to wonder about telling patients about more serious diagnoses that we and our immediate family have had. They may show the patient more of our humanity, but it will also open up our private lives to their gaze. Is this, I wondered, a good or bad thing?

If we overuse a metaphor then it loses its effect, as happened in my home village. If we do not empathise at all then we can be seen as some sort of alien being; cold, aloof and unfeeling. Yet, if we disclose too much then we are in danger of looking too frail. But maybe showing weakness is no bad thing. My childhood asthma means that I can now empathise with children who are wheezing and coughing all night and feel miserable as a result. And there are excellent accounts from doctors who have revealed their personal battles with depression, cancer, and alcohol or drug abuse to their patients with good effect.

Several of my patients with whom I have discussed the recurrent depressive illness I have had over the last 12 years have commented that they feel that I am much more approachable since I had told them. Not because I was ill, although I feel that it did change me as a doctor, but since they now know about it, they see me in a different light.

The subtleties of the consultation and our attempts to put patients at their ease may lead us into disclosure. It is perhaps a good sign that we feel comfortable enough with a patient, and them with us, to be able take them into our confidence. After all, they are expected to reveal their innermost secrets to us at a much earlier stage in the relationship. It leads to more rewarding and fascinating relationships if we are open and honest with our patients. We must be careful that we do not expose too much of ourselves. Equally, we must not overuse a favourite stock phrase or saying, otherwise we risk losing the gravitas that is required to make us healers.

The art of medicine is by no means dead and this is perhaps one of its more interesting aspects. Without it we would lose a lot of the positive things in general practice — the sorts of things that keep us going through an otherwise dull morning of coughs, colds, and bored teenagers with sore throats and their demanding mothers.

Complexity and healthcare: an introduction
 Edited by Kieran Sweeney and Frances Griffiths
 Radcliffe Medical Press, 2002
 PB, 208 pp, £24.95, 1 85775 559 6

COMPLEX and beautiful patterns emerge spontaneously from the interactions of autonomous units operating within frameworks of simple rules. This applies to the swirling of flocking birds; it applies to fractal patterns such as the Mandelbrot set; and it seems likely that it applies to GPs working in the National Health Service.

Complexity is a cross-disciplinary science that has emerged in recent years in an attempt to explain the inner workings of complex systems, which notoriously elude modelling by conventional mathematics. GPs do not need to be told that general practice, never mind the National Health Service, is a complex system. Applying a new tool — in this case, a new scientific idea — is the essence of legitimate change and it is not surprising that forward-thinking GPs have been drawn to investigate what this new science has to offer in their field. The Complexity in Primary Care Group arose in this way, appropriately enough without central direction. *Complexity and healthcare: an introduction* is the account by members of the group of their progress so far.

Their excitement is palpable; they are sure they are on to something new and important. Frances Griffiths, originator of the group and joint editor of the book, makes this clear with a bold concluding remark: 'Complexity theory may be for healthcare what the periodic table was for chemistry'. If this is true we would do well to pay attention!

The book is uneven, perhaps inevitably with eight authors, and at times as you read it, it makes you think that people can see anything they like in complexity theory — similar to the Bible — from chaos to central control. I liked Kieran Sweeney's 'Introduction' and his 'History of Complexity', and also the chapters developing the theory of complexity by Chris Burton and Tim Holt, although these were difficult to follow at times.

David Kernick's chapter on 'Complexity and healthcare organisation' was outstanding and I do urge people not to miss it. I can't do better than quote from his summary: '[the chapter] argues for a metaphorical interpretation and pragmatic application of complexity theory and the development of cultural change through a bottom-up organisational emergence rather than top-down systems engineering.' I took this to mean that, rather than complaining that 'managing GPs is like herding cats', managers who want that kind of life should go and look for some sheep.

Which brings me to Kieran Sweeney's chapter on the application of complexity theory to the 'embedding' of clinical governance. Although obviously clear to

him, what clinical governance means remains a notorious riddle to many and describing it in terms of complexity risks wrapping a mystery in an enigma.

Specifically, I am unhappy about his use in this chapter of the term 'attractor'. To say that the attractor for one practice is 'excellence', while for another it is 'financial gain', is surely not using the term in the sense in which it is used in complexity theory. Here it seems one-dimensional, while complexity theory deals with 'strange attractors' — a much deeper concept involving multi-dimensionality, or even infinite dimensionality. As James Gleick put it in his book *Chaos*¹ (page 137), 'Mathematicians had to accept the fact that systems with infinitely many degrees of freedom — untrammelled nature expressing itself in a turbulent waterfall or an unpredictable brain — required a phase space of infinite dimensions'. In other words, I do not believe 'attractor' should be used as a synonym for priority in the context of complexity theory.

Yet terms like 'attractor' and 'phase space' do help us to understand the behaviour of natural systems. Something like this: if the phase space is the multi-dimensional graphical representation of every parameter of a system, such as the weather (or human behaviour) we cannot say which particular weather (or human behaviour) is going to happen; in other words, which particular point in the phase space is going to be visited at a particular time, but we can say which weather states are *possible*. The inconceivably larger proportion of the phase space is never visited; in other words, is not possible. The areas that can be visited form the attractor, often a stunningly beautiful but deeply elusive entity, almost like the 'structure' formed by a whirling sparkler on bonfire night, but written in countless dimensions.

So complexity science has a lot to say about setting limits, and about then letting beautiful, complex, undefinable things emerge within those limits. Perhaps this is like the way I remember the GPs of early 1970s Britain setting about and completing the huge and sensitive job of weaning their patients from barbiturates to the far safer benzodiazepines (sic), without any central direction or administrative cost whatsoever. My take on complexity theory from this showing is that it has a lot to say about the futility of trying to 'govern' this kind of thing.

We are all invited to share the exploration, the group invites new members and its website www.complexityprimarycare.org provides a welcoming portal of entry.

James Willis

Reference

1. Gleick J. *Chaos: making a new science*. London: Heinemann, 1988.

roger neighbour - behind the lines

Lord of the Rings — The Two Towers
New Line Cinema, 2002
Directed by Peter Jackson

Certificate 12A

BELIEVING in things fantastical is an mandatory part of general practice. So much is unseen, intangible, yet we must believe in it as fiercely as any religious fanatic. I've never actually seen bendrofluazide make anyone better but I must believe it because the statistics say so, and if I can swallow that I can swallow anything.

As I therefore get enough fantasy in my job, I can do without it in my real life. But this time last year I reviewed *The Fellowship of the Ring* for the *BJGP*, and I thought it was a stunning cinematic experience, so good that I wasn't sure if the standard could be maintained.

I was very pleasantly surprised; the sequel is even better. Vast landscapes, superb special effects, a pace that never slows, riveting battle scenes, superb characterisation; this film has it all, reminding me perversely of the *RCGP Members' Reference Book* (without the ads). Like the first film, it's a whopping three hours long, so you'll need two buckets of popcorn, but the time will fly.

As with the original book, the second part is more fragmented. Rather than one linear story, this time there are three separate strands; the war of Rohan, the awakening of the Ents, and Frodo's tortuous journey to Mordor. None of these interconnect, but despite this the film remains coherent. Some liberties are taken with the original plot, but I think they are all improvements.

The atmosphere is quite dark and brooding; throughout there is a feeling of overwhelming evil, that any resistance is futile, that whatever the heroes do they won't win in the end, rather like a Monday morning surgery.

There is so much going on I'm not sure if someone unfamiliar with the book would be able to follow the plot, and the film makes no allowance for this; there is no recap at the start of what happened in the first film, and the action starts immediately. Obviously the filmmakers are presuming you've watched the first one. Highly recommended.

Liam Farrell

On tents

THE week between Christmas and New Year is an odd time. The shift from disgraceful self-indulgence to Puritan resolution will sometimes cause a spiritual abyss to open up, a kind of long dark spastic colon of the soul. Into this void may come visions; but whether they be profundities or merely the products of fermentation is for someone else to judge. Anyway, as I nibbled one last marron glacé before breaking in the new running shoes, I thought now's as good a time as any to fill in my annual — my first — GP appraisal form. (Now come on, of course you've heard of appraisal.) And lo! as I did attempt to answer question 3 on page two of Form 3 (What professional or personal factors significantly constrain you in maintaining and developing your skills and knowledge?) I fell into a dream. And in my dream I was carried unto a high place, whence I saw spread before me even like unto a tented village. And behold! the name of the tented village was General Practice.

Tents, as we know, are of two kinds, classified according to the *locus micturendi*. There are those — let us call them type A — where the golden stream is directed outwards from within. And there is type B. Most of us (if the image is not too unpleasant) have a foot in each, but a predilection for only one. I tend to be a type B man myself. Cynic that I am, I'm usually more alert to the muddle and palm-greasing that spawn the latest good idea than I am to the lofty principles its advocates claim for it. Show me a PCT or a clinical protocol or a new contract, and I'll show you a wigwam wherein my instincts are to point Percy, as it were, *ab exteriore*.

But with appraisal it's been different. Appraisal, when first mooted, struck me as a tent it might be better to be on the inside of. I am, after all, passionately convinced that guided introspection is the best driver of adult learning. And if state-controlled and contractually-required appraisals are the closest we can come, in this near-totalitarian NHS, to genuinely formative reflection — well, I thought, I'll try and make it work. So I put my hand up as a potential appraiser, and in due course (having signed an affidavit to the effect that I was not, as far as I knew, the subject of an ongoing criminal investigation), was approved. I am now licensed, as Sir Liam Donaldson has so memorably expressed it, to help my local colleagues 'consolidate and improve on good performance aiming towards excellence in a positive and supportive developmental process'. Gulp. It is not, not, NOT the business of an appraiser to denounce a duff doc, merely to help him or her to burst into tears and promise to try harder. We remain, after all, a caring profession.

We appraisers thought it best to apply the Delphic injunction, 'Appraise thyself'. So, in order to get a bit of practice and street cred under our belts, we're all doing each other before we go live. X is doing Y, who's doing Z, who's doing X; no chance, you see, of my overlooking your shortcomings if you'll overlook mine.

But here's an interesting question, slipped unobtrusively into Form 3, page 6: 'What safeguards are in place to ensure propriety in your ... use of your professional position?' In other words, are you Harold Shipman? No I'm bloody not. And if I were, what would I put? 'Curses, you got me bang to rights, I'm a murdering psychopath'? It would be interesting to ask him. 'Dear Harold, I enclose Form 3, to be returned in complete confidence ahead of our forthcoming appraisal meeting.'

Oh dear, it's so hard to stay starry-eyed. Maybe I have to redefine appraisal as a type B tent after all, a token exercise in anti-Shipmanism best watered from outside. But there are so many tents, a whole village of them. Clinical governance. Revalidation. Summative assessment. MRCGP. National Service Frameworks. PMS. The new contract. So many issues where whether you are inside or outside the tent is arbitrary, irrational, and ultimately inconsequential, but which, to the individual, seem to matter enormously.

There are two things about tented villages. The first is that they are congregations of the dispossessed, places of hunger, impoverishment and squalor, places where fights are always breaking out, temporary encampments that need urgently to be replaced with more dignified and worthy structures. Secondly, tented villages are the backdrop for countless unsung cameos of individual heroism, self-sacrifice, nobility. Tented villages are where Médecins Sans Frontières come into their own. If it's not an insult to these intrepid guys, maybe in a small way we too could aspire to be GPs sans frontières, the takers-down of tents in our own vernacular wilderness.

Memories of Gaza

MY husband Hans and I went out to Gaza in August 1991, funded by the charity Medical Aid for Palestinians (MAP). I was a surgeon; Hans an anaesthetist. Reviewing my slides recently I was struck by the vivid images of Gaza — the light and heat pounding down on your head during the day, the scent of exotic flowers and trees, the sound of honking horns and braying donkeys as the traffic jousts on the unsurfaced roads. We found the Palestinians a truly Mediterranean people with a love of family and a regard for hospitality.

It was just six months after the Gulf War and tensions were high. While we were not politically motivated in going to Gaza, it was not possible to remain unaffected by what we experienced there. The Palestinians were a 'non-people' with no country, no passports and no human rights.

The Gaza Strip is a small coastal area measuring 40 kilometres by eight kilometres. In 1991, the population was 800 000 people, of whom 500 000 were refugees from the 1948 war or their descendants. The United Nations has maintained responsibility for these people and provides education and basic health care.

We worked at Al Ahli hospital, the only charitable hospital in the Gaza Strip, which through UN contributions provided free inpatient care for all UN-registered refugees. There was no comprehensive primary care service outwith the immunisation programmes and child health clinics of the UN. This certainly kept administration to a minimum as, with no postal service, there was no way of sending a letter and no-one to write to. We worked a six-day week, with clinics and operating lists on alternate days. The clinic opened at 8.00 am and finished when the waiting area in the garden was empty (about 3.00 pm). Patients brought old notes in a mixture of Arabic and English, along with faded x-rays, searching for someone who could cure their problem. We talk of patient-held records as some great new development, while in Gaza there was no other option.

The hospital was situated in one corner of Palestine Square, which was a common site of clashes during the Intifada, with youths throwing stones and the Israeli soldiers responding with plastic bullets and tear gas. It was a regular occurrence while doing the clinics to feel a choking sensation and stinging eyes as the gas wafted right into the hospital.

The plastic bullets commonly used by the Israeli Defence Force looked like the top of a child's crayon and were made of plastic and glass. They were, however, fired using

live cartridges from normal military rifles. This gave the bullets a high initial velocity that rapidly reduced because of their low weight. They were designed to be used at a range of over 50 metres to cause flesh wounds in the legs. But in the heat of conflict they could be used at closer range causing more major injuries and some fatalities, particularly among young boys who were just the wrong height. Less often, when things got really out of control, the soldiers would change to the full metal jacket ammunition (M16) with predictably horrific consequences.

If their wounds were manageable then most patients went home, as the Israeli soldiers regularly raided the hospital and arrested anyone found with bullet wounds. Patients were often hidden above ceiling panels and in other odd corners until the coast was clear.

During our time in Gaza we set up teaching sessions and introduced new techniques such as endoscopy. We also arranged for skill-based journals, such as *Surgery* and *Medicine* to be shipped out. One of my greatest sources of pride was that two of the registrars who worked with me managed to obtain British FRCS qualifications during that period. This was quite an achievement as, without proper passports, it was difficult to travel abroad to access surgical training, particularly from Gaza where even obtaining permission to travel to Jerusalem involved queuing for up to three days.

This type of humiliation was commonplace at every checkpoint every day, and moving around at all was a frustrating experience. Added to this were the frequent curfews which stopped patients travelling or being moved to other facilities.

On one occasion we were turned back at the checkpoint while trying to transfer a young boy with an infected, obstructed kidney to a hospital in Jerusalem. After we were turned back we had to work out an alternative. A kindly cardiologist used his ultrasound skills to identify the best line of approach to the dilated renal pelvis and in the absence of percutaneous urology equipment we used a conglomeration of CVP lines and bits of metal tubing, until at last we hit the target and saw the pus drain from the catheter.

While this episode had a happy ending, others did not. Naema, a 26-year-old mother of two, developed ischaemic bowel owing to a congenital torsion. An Israeli curfew lasting several days was in place, and she was not allowed to travel to Gaza City where she could have received free treatment in our hospital. Presenting late to a local Israeli administered hospital in the south of the Strip she underwent a bowel resection. After four days her money ran out, and she was

A very short history of Palestine

In the West we often talk as if the Arab-Israeli conflict is from some ancient and long-forgotten cause lost in the mists of history. There certainly are longstanding *casus belli*, but other more recent reasons for conflict lie in the resolution of the two World Wars of the 20th century. The power vacuum created by the fall of the Turkish Empire at the end of the First World War led to the British Mandate over Palestine, while at the end of the Second World War thousands of displaced Jewish holocaust survivors needed a homeland. Unfortunately, Palestine was already crowded, with finite space and water. Britain washed its hands of the situation in 1947, handing the mandate back to the newly formed United Nations, who suggested the partition.

After the first Arab-Israeli war in 1948 the state of Israel came into being, with Palestinians fleeing into Arab controlled areas — the West Bank under Jordanian control and the Gaza Strip under Egyptian control. Both came under Israeli occupation after the Six-Day War in 1967 and have remained so ever since.

Poor old Joe

THE NHS is being destroyed, its staff demoralised, by the government's pig-headed insistence on the primacy of waiting list targets and its failure to acknowledge its own realisation that things cannot get better in a hurry. The PCTs in my neck of the woods have inherited huge debts from the old Health Authority. Nobbled by too many emergency medical admissions and not enough staff and facilities, and made worse by Norwalk virus closing sometimes seven wards at a time, we are way behind on our surgical targets, especially in orthopaedics. Our Trust realised that we could either achieve our financial targets, or we could go for our surgical targets. Orders came from on high: you must achieve both. But we can't. Our Chief Executive has just resigned. There are now no Chief Executives left in Avon Trusts. The Chief Executive of the new Strategic Health Authority, sent in to sort us out, went to the government to say it was impossible without more money. He was sacked.

The government's idea is to employ outside teams. Why on earth would anyone be interested? A health minister explained on BBC Radio 4 that the only important thing was to get the best people in to turn failing hospitals around, and if those teams were in the private sector (BUPA was mentioned), then so be it: new brooms sweeping clean.

The radio presenter patiently asked whether this meant the private concerns would get more money from the government or would be able in some way to cut back their services, because the whole purpose of private concerns was to turn a profit. The question was side-stepped three times before the only possible answer was given. And private concerns, as the presenter correctly said, run smallish hospitals doing routine work. They don't like complicated cases and chronic diseases.

Scrabbling around for other answers to his unanswerable waiting list problem, Mr Milburn is proposing DTCs — 'Diagnostic and Treatment Centres'. What do we do in hospitals if not diagnose and treat? But never mind. Are the DTCs going to take on the complicated stuff on the risky patients? Will the DTCs, run by profit-minded private companies, be happy with specialist registrars learning their skills, and medical students taking up precious operating time? So we poor saps will still have the problem of medical outliers, but all our surgery will be complicated, and teaching and training will suffer as well.

Which doesn't leave me much space for Joe Strummer, lead guitarist with The Clash, to whom the *Daily Telegraph* [sic] of 24 December gave the whole of page 3 and half its obituaries page, and who never took tea with Tony Blair. Rest in peace.

Nev.W.Goodman@bris.ac.uk

discharged with faeces pouring from both abdominal drains, an NG tube in place and a Venflon, connected to nothing. After languishing at home for several days a nurse friend of the family suggested that they bring her to me. I have never seen anyone so ill who was still alive. She was grey and in septic shock. Her fingers were necrosing and unfortunately her abdominal wall was in the same state. The stoma had fallen apart and was pouring faeces into her peritoneal cavity and the layers of her abdominal wall. We operated on her five times, resecting most of her bowel and debriding almost all of her anterior abdominal wall. She struggled on for three weeks and at one point I even thought we might win. However, with only limited access to intravenous antibiotics, sepsis maintained its grip and I began to see the inevitable end. Naema saw it too and I cannot forget the look of anguish on her face when she learnt of the final insult — another curfew meant her husband and children could not visit her that day. They never saw each other again.

Now, with the news filled with the casualties from suicide bombers and Israeli tanks, I wonder how hopes for peace have poured away so completely. For we were there on the first morning of the Madrid Peace conference in September 1991. It was a tense day but as it wore on it became clear that the vast majority of Palestinians supported the peace initiative and we saw youths giving olive branches to Israeli soldiers. 'Land for Peace' was the brave proposal of Yitzak Rabin and Shimon Peres, which was meant to be brokered politically and financially by the USA and Europe.

After the assassination of Rabin, momentum was not maintained by the West and eleven years of fruitless negotiations have left politicians with little to show, and the fundamentalists, such as Hamas, almost unassailable. Now there is a second Intifada and no real peace process, only smouldering tatters.

After the appalling horror of 11 September 2001, President Bush declared war on terrorism and its causes, promising to tackle the Arab-Israeli conflict. At present, however, we are side-tracked in old battles with Saddam Hussein, while the cauldron of Palestine overheats in tit-for-tat destruction between Israeli forces and suicide bombers.

To have any hope of a peaceful solution in the Middle East it is crucial to understand the roots of this conflict but for the region to have any future they must let go of the past and move forward.

In the present deadlock neither side can win but we can all lose.

Philippa Whitford

our contributors

Mike Cohen is a GP and trainer in Westbury on Trym, Bristol
Michael.Cohen@gp-L81017.nhs.uk

Peter Davies is PMS principal in Halifax, Yorkshire. He is a regular contributor to **hoolet**, the best thing about RCGP Scotland
Alisonlea@aol.com

Hilary de Lyon is the new Chief Executive of the RCGP. First impressions are reassuring — a twinkle in the eye and self-confident scarves

Liam Farrell is surprisingly rude about the new College tartan in a recent issue of *GP*. He continues to write for the *BMJ*, has completed a series of television programmes for Ulster TV, and runs the Roscommon Musical Festival. In between times he's a GP in Crossmaglen
drliamfarrell@gmx.co.uk

Neville Goodman is a consultant anaesthetist in Bristol
Nev.W.Goodman@bris.ac.uk

Seth Jenkinson is a GP in East Kilbride, Lanarkshire, Scotland
Alisonlea@aol.com

Elizabeth Mitchell is a lecturer in health informatics at the Tayside Centre for General Practice in Dundee
e.d.mitchell@dundee.ac.uk

Alan Munro is a member of MREC Scotland — alan.munro@virgin.net

Roger Neighbour will stoop to desperate lengths to win bottles of champagne. Readers are advised to remain alert for unusual Laland Scotticisms in forthcoming columns

Trefor Roscoe is a GP in Hackenthorpe, Sheffield

Graham Smith remains an oral historian in Sheffield —
Graham.Smith@sheffield.ac.uk

Philippa Whitford is a consultant breast surgeon in Kilmarnock, Ayrshire. She was once bitten by an Australian who thought he was a barracuda
philippa@whitfordpieper.co.uk

James Willis is President of the Wessex Faculty of the RCGP. Lucky Wessex Faculty! Among a million other enthusiasms he has embarked upon a degree in humanities at the Open University — james@jarwillis.fsnet.co.uk

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

alan munro

Fashions

THE man had just had a coronary. Hesitantly, with uncharacteristic concern for his ideas, concerns and expectations, I broached the subject of tobacco.

'You are being exceptionally gentle today.'

'It's fashionable for docs to try to be nice', I said, defensively.

'I've been getting a hard time about the fags from you guys for twenty years. I remember a red-faced, red-haired old fellow, sitting with his feet up on the desk giving me a roasting for having the cheek to bother him about my ulcer while smoking still. His rather brown fingers, meanwhile, were busy with tobacco and paper making himself a roll up. I said "Doc, I can't help noticing that you are smoking yourself." His face swelled. He slowly put his feet on the floor, leant forward, thumped the desk, and bellowed "I'm not f***ing complaining!"'

I felt pleased that I had been fashionably gentle, but at the same time was aware of a scintilla of regret that perhaps I had been born twenty years too late.

Fashions are intriguing. Some are more lasting than others. Plato gave us the notion of moral perfection in a metaphysical universe, and of the primacy of man in that universe, which proved durable for two-and-a-half thousand years. My favourite day dream is that this is a fashion which has had its day. Philosophy will henceforth be footnotes, not to Plato, but to my hero, Darwin. I love the man for the soaring, delirious sense of freedom that comes with relocation to a material universe run by reproductive perfection.

The sheer, stark, naked simplicity of the idea is utterly captivating. You and I, the dog lying on my feet, the woodpecker on the nut feeder and the tree it has just flown out of, are all here because we represent strands of evolving, reproductive perfection. When I, as I regularly do, nearly crash my car goggling at a bus queue of sixth-form girls, I smile at the thought that the old seed factory is still on the prowl for suitable incubators. If I ponder the evolutionary and cultural restraints upon my actions in this field, the irony is less than excruciating and I'm still smiling, if a little crookedly. Conflicts and inconsistencies are what an evolved, layered self awareness would expect of itself. They are a sufficient burden, without an oppressive duty morally to perfect one's self, and they are the source of lots of laughs.

Our most cherished and allegedly defining human characteristics, like altruism, in a Darwinian world are not matters of painful moral training, but rather are free expressions of an inherited talent for reciprocity. Human beings turn out to be rather likeable, even dodgy old doctors with unreliable driving habits. I like myself and my fellows a little better, embedded in an evolutionary world.

I love the idea that we have been culturally up a cul-de-sac for a millennium or two. Copernicus started the banishment of humans from the centre of the universe, and Darwinians have contributed with style. Not only are we just one among many highly evolved organisms, but all organisms are mere vehicles invented by genes, battle chariots in their survival wars. From chip off a divine block to gene convenience in a century or two. Fickle fashion indeed.

I should like to start a soundly Darwinian fashion myself. If I am nothing more than a gene conduit, then it is clearly unreasonable to expect me to know much. So, I propose to answer nearly all questions in future by saying 'I don't know', particularly to two-year-old grandchildren. In this way, if my fashion is adopted, a generation will grow up which is comfortable with not knowing. Not such a big deal? Imagine a race of patients content with some things being unknowable!

The mail has arrived. Our postie is a fund of stories. It turns out that he was at school with my solicitor, and furthermore that the same gentleman holds the Dingwall Academy all-comers, heavy weight, continuous swearing record. Eccentrically, performance in this discipline is measured in miles, specifically the distance travelled by the school bus while the competitor swears without hesitation or repetition. This sort of inspired nonsense is metaphysically invisible, irrelevant in the grand Platonic scheme of things. But in a Darwinian world, words and our capacity delightfully to arrange them, are as tail feathers, tokens in the great reproductive game. Gossip, unlike consultation models and other intellectual edifices, will never go out of fashion.