The Back Pages

viewpoint

A brief history of time off work

NONE of my patients is much like Stephen Hawking, but I thought of him as I wrote a letter to a probation officer about a patient's fitness to work. It occurred to me that if somebody as spectacularly disabled as Hawking can work, then nobody can be said to be too disabled to work. I surmised that the ability to work depends on three interlinked and interdependent factors.

Firstly, the talent and training to do a job that exists out there in the job marketplace; secondly, the motivation to do it; and thirdly, the social support that allows you to do it. The patient I was writing to the probation service about had none of these three, and without massive rehabilitation was frankly unemployable. I had recently returned to work after badly breaking my ankle and these ruminations were provoked by the obvious fact that I was more disabled with my still painful gait than many of the people for whom I signed sickness certificates. I was back at work because I am fortunate enough to be trained to do a job that pays well. I am motivated to work because I enjoy the job, and it pays me enough to motivate me. Lastly, my job is sedentary, I can drive to within a few yards of my desk, people bring me cups of tea during the day and they are obviously appreciative of what I do.

So when we sign a sick note we are really making a socially constructed judgement about some or all of these three factors in a person's life. I remember seeing a television programme a while ago at a time when there had been some publicity about allegedly excessive numbers of people being on long-term disability pay. The journalists had gone to Merthyr Tydfil, which apparently has the highest prevalence in the country of such claimants. What appeared to have happened is that when the steel industry, with its ageing workforce, had suffered the sharp contraction of the 1980s, lots of middle-aged men with arthritis, back pain, COPD and such-like had become 'sick' rather than be unemployed. Their disabilities hadn't changed, but the job market had moved away from their skills, with consequent effect upon their financial and psychological motivation and social support. A local GP was interviewed by the journalists, and he doggedly insisted that these people really were 'disabled'. What neither he nor the journalists, nor I until recently had realised was that their 'disabilities' were not the reason they were not working, or even looking for work.

This phenomenon is an aspect of the exaggerated importance of medicine in our culture, and how we as practitioners get sucked in to a posture of medical megalomania, imagining that the medical labelling of something transcends other social, political or emotional aspects of a problem. I take it as a weird kind of compliment paid by society to doctors in general and me personally, as if I would somehow know if a thing was right or not. When I sign disability parking Orange badge, or bus pass forms, I am merely ratifying what a patient has told me. Do I walk up the hill outside the surgery with them to see how far they can get? Well, no I don't. And even if I did, could I be sure they weren't shamming?

This ratification of patients' self-assessment of their inability to work, coupled with the patients' belief in our powers does, however, create a serious problem. There is a danger that by confirming them in the sick role we actually contribute to their ill health and make it more difficult for them to get better or think of other ways of dealing with their problems.

There is the famous paper by Haynes *et al* about the 'labelling' of hypertensive steel workers,[1] which actually made these previously symptomless men consult the doctor more and take more time off work. In other words, the 'caring' posture of institutionalised medicine actually generates dependency, maladaptive behaviour, and ill health. The insights of cognitive therapy suggest that by rehearsing 'bad' thoughts, they are reinforced, so it is at least plausible that by colluding in our patients' categorisation of themselves as unfit, we actually make them unfit. This is another medical contribution to ill health. The more you look the more you find.

Thank you, Stephen Hawking.

Seth Jenkinson

Reference

1. Haynes RB, Sackett DL, Taylor DW, Gibson ES, Johnson AL. Increased absenteeism from work after detection and labeling of hypertensive patients.*N Engl J Med* 1978; **299(14):** 741-744.

"How is it possible to ensure that these patients, excluded from clinical trials, marginalised by society and possessing numerous problems, receive the best care the NHS can provide?"

Hard Lives: a personal view
Una Macleod, page 418

"General practice is a reflection of life. You are so aware of life and death. … You see people growing older and you see what life does to them …"

Andrew K, reflecting on general practice, in **Paisley Docs 12**, page 421

contents

‘Hard Lives’— Conference, 4 April, Glasgow

Health Inequalities Standing Group, RCGP
www.rcgp.org.uk/rcgp/clinspec/hineqgr1.asp

Department of General Practice and Primary Care, University of Glasgow
www.gla.ac.uk/departments/general practice/

West of Scotland Faculty, RCGP
www.rcgp.org.uk/rcgp/faculties/wscot/index.asp

THE West of Scotland Faculty and the RCGP Health Inequalities Standing Group hosted a day conference in March to ‘consider the impact of the combination of multiple illnesses and socio-economic hardship on patients’ lives and to develop strategies for primary care organisations that can mitigate these problems’. It was entitled ‘Hard Lives’ and the organisers hoped that ‘it will generate an agenda for clinical governance in this area, which will be circulated widely to primary care organisations and to NHS policy makers’. It was held in the impressive new Wolfson Medical School Building at the University of Glasgow.

The participants came from a range of backgrounds, which created an invigorating and productive multi-disciplinary atmosphere for the discussions and case studies. There was also a creative mix of academic and frontline practitioners. I sensed an occasional tension between some of the academics and those from the coal face, particularly when discussing our patients’ culture and our own values. There was a recurrent debate about language and the words we use. Working in deprived communities means that we have to cope with more ill people who have more illnesses. But how do we describe this? How should we research it? How can we communicate our concerns to commissioners and clinical governors?

I was confronted with the new idea that my patient is ill with her depressed diabetic heart failure as one experience that she is handling within the context of her housing, education, and employment difficulties. Is this one morbidity or many? Is it one diagnosis or many? How do I tease out all the important, relevant factors of each problem without losing sight of all the problems? How many clinics will she have to attend so that I can maximise my Quality Payments? How do we share this with our students?

I wondered how our discussions would have been informed and influenced by the opinions and experiences of our patients. The day was taken up by our conversations about and considerations of them and their experiences. As a student 25 years ago I had the privilege of hearing the wise South Wales Valleys pioneer Alistair Wilson, who used to bring patients with him from Aberdare so that we could hear their stories too. We talked a great deal about listening to our patients’ stories in the plenary session; perhaps at next year’s conference we will hear them too.

The grand height of the doors into the lecture and seminar rooms made us feel suitably small and humble as we entered this great cathedral of learning. For many of the participants the conference was an opportunity to go on ‘retreat’ from our own hard lives in a comfortable, confident, and consecrated atmosphere. The conference

‘Hard Lives’: a personal view

QUALITY is the context in which we live and work at present. The government, primary care organisations, the proposed new GP Contract, all speak of and direct us to achieving higher quality care for our patients. It is hard to argue with the appropriateness of this.

Sometimes in the talk about the drive for quality targets, it can seem relatively straightforward. How difficult is it to ensure that a patient with ischaemic heart disease has appropriate anginal therapy, antiplatelet and statin therapy, and adequate blood pressure control, smoking, and dietary advice? Well maybe not that easy anyway, but add to this scenario osteoarthritis, poor mobility, and chronic anxiety regarding a drug-abusing family member. It is in this real world that primary health care teams work, the real world of multiple multi-dimensional problems and it is in this world that attempts to achieve quality must be made. Therefore the current drive towards managed care and disease-based clinical networks raises issues for the management of patients with multiple physical, psychological, and social needs.

Recognising the difficulties of this — especially for patients living, and practitioners working, in socio-economically deprived areas — was the purpose of our conference. An outcome will be an RCGP consensus statement on the role of clinical governance with respect to co-morbidity and deprivation in primary care.

For me, this conference was another step on the path of trying to understand co-morbidity and the impact of this on our patients and on their professional and family carers. This path started with research exploring why socioeconomically deprived women have poorer outcomes from breast cancer than affluent women. Surprisingly to us at the time, it appeared that co-existing physical illness was one explanation for this.[1] Several years of general practice in Glasgow have intensified this interest.

How is it possible to ensure that these patients, excluded from clinical trials, marginalised by society, and possessing numerous problems, receive the best care the NHS can provide? These were the sorts of issues I hoped would be raised at this meeting. There was no doubt that the attendees at this conference understood the complexity of achieving best outcomes and appropriate care for patients with multiple problems. The meeting was largely workshop-based, and although as participants we didn’t produce definitive answers to these complex issues, we did

1. Macleod U, Ross S, Twelves C, *et al*. Primary and secondary care management of women with early breast cancer from affluent and deprived areas: a retrospective review of hospital and general practice records. *BMJ* 2000; **320:** 1442-1445.

was about our patients, but I found it very comforting to hear about how others are struggling as I am. In the workshops and the plenary session we shared our own multiple morbidity, our own deprivation and the impact that clinical governance and the proposed new GMS Contract would have on us as clinicians and service providers. There was also the 'I'm thankful I'm not as badly off as you' moment as we heard from colleagues without a psychiatric service or with particularly difficult and complex patient problems.

A great deal of concern was voiced about the future: is the new GMS Contract the end of what we value in general practice? How can we prove what we value in our work? How do we develop and learn this new language about many complex problems? What skills do we need to grow and strengthen the partnerships that we need, to help us to help our patients?

All in all, it was a great day and it re-invigorated me. I journeyed home wondering what my unsung colleagues who have served the Valleys of South Wales and the other deprived communities of Great Britain all of their working lives would have made of our deliberations. Are they the left behind in the communities of the left-behind?

Jonathan Richards

provide some insights.

Firstly, patients need to be treated as people and not as diseases. Are we in fact witnessing a drift away from holistic care to the care, not even of diseases, but of quality indicators? Are we measuring the measurable, and valuing that, rather than thinking about this from a patient-focused viewpoint? Secondly, we need to involve the whole practice team and engage in appropriate and relevant collaboration with secondary care, social care and the multidisciplinary research community.

Finally, and perhaps most importantly of all, we need to understand the potential perverse effects clinical governance demands may have on practitioners in struggling deprived areas. Patient care may suffer instead of being enhanced and, as such, clinical governance ought to be a learning tool, not a performance management tool.

Interestingly, we couldn't agree on terms; definitions were easier. What is appropriate usage of language — co-morbidity, co-existing disease, multiple morbidity? Any thoughts on the usage of these terms (or others) to **u.macleod@clinmed.gla.ac.uk**

Una Macleod

flora medica theophrastus bombastus

From the journals, March 2003

***New Engl J Med* Vol 348**
883 Low-dose aspirin reduces the incidence of colonic adenomas, with or without previous bowel cancer.
900 A study of urinary incontinence following vaginal delivery, showing that it is reduced — but not eliminated — by caesarean section.
977 In this UK study, peanut allergy was shown to be triggered by the use of peanut oil in many emollients applied to atopic skin.
1085 Do I look fat in these genes? The current front-runner seems to be the melanocortin 4 receptor gene, different polymorphisms of which are associated with familial obesity and binge eating.
1223 A study of opioids in chronic neuropathic pain and, on page 1243, a very good review of the painful neuropathies.

***Lancet* Vol 361**
799 Electroconvulsive therapy has had a bad press, but this systematic review shows that it is highly effective for depression.
809 There was some excitement when computer database studies appeared to suggest that macrolide antibiotics might prevent coronary events, but this trial of azithromycin (AZACS) shows no effect on acute coronary syndromes.
859 Throughout the month, the *Lancet* ran a series on prostate cancer: very good if you want to reach a state of better-informed uncertainty.
889 You probably have at least one patient with recurring optic neuritis, so you should read this editorial, and also perhaps ***Neurology* 60: 848-856**, which contains a fuller discussion of the features that predict neurological and visual deterioration.
891 A down-to-earth study showing the benefits of postnatal visits to teenage mothers: proof that GPs should read the *Lancet*. Sometimes.
977 And more proof: a leader on primary care research, castigating us for talking it down.
978 Previous trials of treating bacterial vaginosis to prevent late miscarriage or premature birth were disappointing, but this one shows that clindamycin makes a difference.
1071 How should we treat mild persistent asthma in children? Regular inhaled budesonide definitely works, but at the expense of a measurable difference in average height (1.34 cm). So don't be put off adding in montelukast by the *BMJ* review of monotherapy (***BMJ* 326: 621**), but use it to avoid higher steroid use, as demonstrated in ***Thorax* 58: 211**.
1119 Curing oesophageal reflux at present means open fundoplication, but there are some experimental walk-in endoscopic procedures that could provide an alternative to lifetime proton pump inhibitors. It could cure your cough, too (see below).

***JAMA* Vol 298**
1107 'I just want to sort out Mum's drugs with you, doctor': consider the time well spent. Adverse drug reactions in the elderly are common and often serious.
1251 Elevated levels of homocysteine mean that you are short of one or more of the B vitamins pyridoxine, folic acid or cobalamin, and that you are at greater risk of cardiovascular disease; and, in the case of this study, heart failure.
1288 Screening always causes harm — in this case, having to collect stool samples and have things stuck up your bottom while you worry about bowel cancer. But this review argues that it's worth doing.

Other Journals
Hospital admissions are commonly used as an end-point in chronic disease management trials, but is it possible to generalise across different health systems? A Canadian self-management programme for chronic obstructive pulmonary disease reduced all-cause admissions by over a half, so it is well worth looking at: ***Arch Intern Med* 163: 585**. Page 688 looks at routine monitoring of enzymes in over 1000 patients taking statins: there were no cases of significant transaminase elevation and only two with increased creatine kinase. ***Ann Intern Med* 138: 365** reports a marked reduction in illness and absenteeism in type-2 diabetics who were randomised to multivitamin supplements. Page 383 reports that weight loss is associated with higher mortality rates only if it is unintentional: deliberate attempts to lose weight reduce all-cause mortality.
Ever heard of gluten ataxia? Wheat gliadin allergy is the most common cause of sporadic ataxia in middle age, according to ***Brain* 126: 685**. In recent years, acid reflux (gastro-oesophagal reflux disease (GORD — or GERD, depending on Atlantic orientation) has emerged as a common cause of chronic cough, and most respond to a trial of proton pump inhibitor for at least four weeks (***Chest* 123: 679**).
About to pack your suitcase? Check out 'Sun protection offered by fabrics: on the relation between effective doses based on different action spectra' in ***Photodermatol Photoimmun Photomed* 19: 11**.

Plant of the Month: ***Stauntonia hexaphylla***
A big evergreen climber with beautiful dark young leaves followed by dusky pink waxy bells of flower, wafting sheets of scent: oranges, honey, and jasmine.

An oral history of general practice 12: Reflections and the history

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

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

At the end of their interviews, the doctors in the Paisley project were asked to reflect on their careers and many talked about disappointments. For example, among those who entered practice before the mid-1960s there was a belief that becoming a GP could still be perceived as evidence of their failure to enter hospital medicine.[1] While they worry that, historically, GPs might be thought of as inferior to hospital doctors, these older practitioners counterpoised this concern with recollections of the pleasure they had derived from delivering patient care. Their disappointment was with the lack of status afforded to general practice within medicine, rather than with their patients or general practice itself.

There was a sense of frustration among those who joined practices from the late 1960s onwards that general practice had not met their expectations. They had directly experienced the improvements that had flowed from the 1966 contract, but were then subject to a series of government interventions that were widely believed to be unhelpful to GPs. From their perspectives, the promises of the Charter had given way to inadequate political fixes, external surveillance, and increased paperwork. One doctor described these developments as the 'crap' that should have been 'cut out'.[2]

Unlike the oldest generation, these GPs were more likely to recall their lives as a 'whole chunk'[3] and were less likely to separate what they saw as the private from the public, including family from work. While older retired practitioners might question the relevance of questions about their family lives in the interviews, younger doctors tended to reflect on the ways in which their work impacted on their lives outside practice, as well as the ways in which personal experiences shaped their approach to medical practice.

This was particularly evident in the recollections of the women who were still working as GPs at the time of the interviews. They believed that they had brought a range of useful personal life experiences into practice, including motherhood and caring for older relatives. Paradoxically, however, their working lives often seemed problematic, because meeting commitments inherent in these experiences were constrained by the ways in which practices were organised.

As with their older practice partners, younger men and women believed that caring for patients and their families had made their work in practice worthwhile. Almost all of those who reflected on their working lives also recognised the stresses involved in being both professional and business minded. Family doctors have historically been expected to embrace entrepreneurial and professional ideals at the same time. This is in spite of the tension that exists between the entrepreneurial model, which 'called for as little state interference as possible', and the professional model, which 'looked to the state as the ultimate guarantor of professional status'.[4] With government policies balanced between these two ideals for a large part of the first 30 years of the NHS, it is unsurprising that most GPs said that they had felt that general practice often lacked direction.

In the 1980s there was a change in 'the master conflict of professional society' between the public and private sectors over taxation and government spending.[5] The 'integrity of the professional'[6] began to be challenged and the service ethos across the public sector undermined. During the same decade there were rising expectations and demands from patients and politicians, including a growing 'intolerance of risk'.[7] Then, in the next decade, the 1990 Contract resulted in raising both hopes among the more entrepreneurial-minded GPs, and fears among those who were less persuaded by market rhetoric.

The youngest of Paisley's GPs seemed to face the worst of all possible worlds. Not only was professional status under threat, but those who had harboured entrepreneurial dreams in the early 1990s were also disillusioned. Three of the younger male GPs have left practice since I finished interviewing in April 2001. One has joined NHS 24, another has left to work for a drug company, and a third has emigrated and left medicine completely.[8] Yet, two of these doctors had expressed a strong commitment to primary care. For example, replying to the question of whether he would remain in practice one said, 'I'm certainly not looking to change'.[9]

Disappointment itself has changed. Ian Craib, the sociologist and psychotherapist, who died late last year, wrote about the need to tolerate and make use of our inner turmoil, the uncertainties, contradictions and paradoxical situations we find ourselves in, so that we can improve ourselves as citizens of an imperfect world. He also pointed out that many of us lack an appreciation of the value of disappointment. 'The important thing about the society outside our heads is that while it provides us with all sorts of opportunities, it must also provide us with disappointments … Changes in society can change my life without my having any understanding of how these changes come about.'[10]

I would like to thank the Paisley Docs for the time and energy they expended in trying to improve our understanding of how changes come about.

References

1. Younger GPs were much less likely to believe this. See: Smith G, Nicolson M. An oral history of everyday general practice 6: Beyond the practice: the changing relationship with secondary care. *Br J Gen Pract* 2002; **52:** 484; 956-957.
2. GPP 22.
3. GPP 15.
4. Perkin H. *The rise of professional society: England since 1880*. London: Routledge, 1989; xiii.
5. Perkin H. *The Third Revolution: International Professional Elites Since 1945*. London: Routledge, 1996.
6. Paxman, J. *Friends in high places*. Harmondsworth: Penguin, 1991; 110.
7. Willis J. *Friends in low places*. Abingdon: Radcliffe Medical Press, 2001; 146.
8. At least one other member of Paisley's youngest generation who was not interviewed has also left general practice.
9. GPP 04.
10. Craib I. *The importance of disappointment*. London: Routledge, 1994; 81-82. See **http://www.guardian.co.uk/obituaries/story/0,3604,897578,00.html**
11. GPP 13.
12. GPP 07.
13 GPP 16.
14. GPP 30.
15. GPP 25.
16. GPP 28.
17. GPP 21.
18. GPP 17.
19. GPP 12.
20. GPP 18.
21. GPP 08.
22. GPP 23.
23. GPP 29.
24. GPP 25.
25. GPP 05.

The oral evidence

Hector M: *'I enjoyed it so much. The joys and sorrows of it: confinements; getting people better; listening to their problems* [pause]. *And I hope I didn't make many mistakes. Of course I must have made some mistakes … In a way I regretted* [retiring], *because I enjoyed the work, but I didn't regret not having to go out at night'.*[11]

Robert E: *'I had been in practice from '52 till '89 … Looking at them nowadays, with all their gadgets and computers and things, I am glad I am out of it. But … if I was starting again I wouldn't want to do anything else.'*[12]

Douglas H: *'My year as an intern or a resident was a highlight year, because it was full of experience, which was available at that time … My army career was a highlight … And then probably we would move to the introduction of the Charter and being able to acquire better premises, better equipment, better assistance and whatnot — that was a highlight … It was obvious we were seeing practice becoming more what you imagine it to be …'*[13]

Stewart McC: *'I am still quite happy working as a GP … The thing I've liked about it is just being in contact with people and getting to know them and being able to do things for them and also being appreciated by lots of people.'*[14]

Andrew K: *'General practice is a reflection of life. You are so aware of life and death. … You see people growing older and you see what life does to them …'*[15]

Fiona T: *'I've been twenty years a doctor and I can't think of anything else I'd rather do. I haven't lost my enthusiasm for it. I still can say to students, 'Yes you've made the right choice … yes, it will be hard work, it will be frustrating …' It saddens me to read about … lack of morale … There is nothing I'd rather do.'*[16]

John H: *'What we all went through prior to the split up of the last practice was a dreadful low — it was terrible and affected me as a person, took a couple of years to get over. … I still enjoy the job I'm doing. There are times when you are under stress, times when you are frustrated. But they are far outweighed by the benefits, the good points.'*[17]

Gavin W: *'There have been good bits and bad bits … I still think that essentially I've done the right thing with my life. It's not been without fret and worry at times, fear sometimes, pleasure, challenge … After virtually thirty years of night work I've had enough and I thought I don't want to go to the police station to see if this junkie is fit to take his proscribed methadone which he says he has to have at three o'clock in the bloody morning … There are times when I break out in a cold sweat and think, 'Oh my God, what have I done?' … Hopefully you go back, look at it, and you've been OK … We're all capable of setting off down the wrong road for quite simple reasons. It might be because of something we did or saw yesterday, a different patient with some other problem, or maybe because your wife's car has broken down and you've had to do the school run and you've come in here all hot and hassled. It is a job that can carry an immense lot of pressure.'*[18]

Eleanor H: *'I mean there are some days when you come back and you are absolutely drained. I used the term 'cared out', because you have listen to so many people's problems during the day. You know I can remember coming back and just wanting to have an hour's peace and quiet and you know the children suffered … And you had to very consciously switch off and make time for them.'*[19]

Linda F: *'Maybe I take responsibility to my patients far too seriously. I'd take that on board and I'd accept that. But litigation is around the corner all the time … My mother died about four years ago and I thought, 'What am I doing?' I wasn't really enjoying working very much. There were difficulties in the partnership … About a year and half ago I was considering leaving and getting a job elsewhere …* [But] *it has taken thirteen years now to remember lots of things, to have it in this filing cabinet that's in my brain somewhere … you know the family relationships … I think we have the kind of practice where a lot of our patients regard us as friends as well as doctors.'*[20]

Carol S: *'I wouldn't want my daughter to do what I have done, because there hasn't been time for things that I would have liked to have done for myself. So the priority was family and work and there was no other time, no other time … I will be 55 and I won't be here … Well, we're going sailing. We will sail round the world slowly* [laughs].*'*[21]

A recurring theme among the doctors was that successive governments had failed to improve general practice and had imposed policies that were harmful.

Robert B: *'When I was a boy I didn't think there were any poor GPs … It was a shock to realise that you had to live to a budget … It could be an absolutely marvellous job … and the answer lies somewhere between adequate funding and a satisfactory level of consumer control … There has to be a degree of public responsibility … but it would cost votes.'*[22]

Jennifer W: *'I just don't like the way general practice is going. You have got to be a businessperson, businessman … Starting again? I would swither hard* [be hesitant] *… I wouldn't have encouraged my children to go into medicine. The country can't afford it and never will be able to afford the NHS. No I wouldn't go into general practice — definitely not … I mean lots of happy memories … I did enjoy it.'*[23]

Donald W: *'In 1990 I kind of thought … just jack it all in* [laughs] *… All sorts of nonsense was thrust upon you … The idea that because you were financially responsible you might adjust what you were doing! I mean you do blood tests on the clinical need not on how much money you are spending ... There isn't any doubt that there's a vast amount of money spent on the health service, probably inappropriately, in various ways like carpeting all sorts of fancy offices.'*[24]

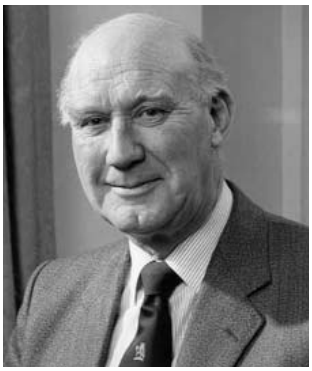
Unhappiness with practice was frequently expressed by the youngest GPs, although their evidence also suggests that satisfaction had continued to be derived from patient care.

Brian R: *'I find it a bit more than irksome that my friends who are lawyers and accountants earn double what I earn, three times what I earn. I find that irksome and yet talking to a lawyer friend of mine who is a corporate lawyer, a very, very wealthy chap, he says that he would like to do something a bit more public sector-orientated …*

'I also like the idea of general practice being a business … I just think it gives you more commitment to what's going on in your practice … I think I do see myself staying here in this practice, but not forever … The best thing's making folk better. Coming up with the right diagnosis and explaining it to patients in a way that they know that they are going to get better …'[25]

Graham Smith

john lawson - an appreciation



JOHN Alexander Reid Lawson was born in 1920 and died in October 2001. His life was spent in Dundee; it was there that he went to school, and where he practised from 1948 until 1986.

He qualified at St Andrews in 1943 and in 1944 he joined the Royal Army Medical Corps, where he immediately found himself in the jungles of Burma as Regimental Medical Officer to the Camerons in a bitter and bloody conflict. After demobilisation in 1947 as a major, and after a number of hospital posts, he began his practice in Dundee in 1948.

His involvement with the College began when he became a foundation member in May 1953 and culminated in his Presidency, which lasted from 1982 to 1985. He first became a member of Council in 1964 and subsequently held many offices, including Chairman of the Publications Committee, Chairman of the Education Committee, and Chairman of the Joint Committee for Postgraduate Training in General Practice. He also found time to become Chairman of Scottish Council from 1965 to 1968, and was Chairman of RCGP Council from 1973 to 1976.

Although not an academic, and in some sense not an intellectual (not unusual among our presidents), he nevertheless inspired the trust and confidence of his colleagues, a confidence that was securely based upon his equanimity, his balance, and his judgement.

His presidency was a time of relative peace in the affairs of the College. The Chairman of Council was Donald Irvine and the relatively young turks, such as Denis Pereira Gray, Paul Freeling, and Marshall Marinker were beginning to make their presence felt. Other important figures were George Swift, Pat Byrne, John Horder, John Fry, Clifford Kay and Ekke Kuenssberg. John Lawson had no difficulty in correcting error or unwise initiatives. He also had a good relationship with the heads of the other Royal Colleges, which was both useful and important. In 1984 he gave the Victor Johnstone Memorial Oration to the Canadian College of General Practitioners.

John was tall and striking, and never looked better than when dressed in Scottish formal evening wear, complete with kilt and sporran. He was of a generation that regarded smoking as normative and enjoyed his cigarettes and his whisky. He had a delightful sense of humour and was a marvellous companion at dinner after the rigours of Council meetings.

In 1944 he married Pat; she provided the secure foundation of his life and was an active President's wife, accompanying John on many of his necessary trips. They had four children — two sons and two daughters — and ten grandchildren, and were a united and devoted family. Both he and Pat were most generous hosts and staying with them was unalloyed pleasure.

John was keen on sport — as an undergraduate he played both hockey and cricket for his university. He was a good shot and was an enthusiastic visitor to Murrayfield, but his first love was golf and his membership of the Royal and Ancient at St Andrews gave him enormous pleasure. He was good at the game and had a single figure handicap. He also loved his garden at 'The Ridges', a formidable hill running down towards the sea.

Through all this time he was a busy practitioner and a much-loved trainer. He also found time to be Regional Adviser in General Practice from 1972 to 1982.

In 1979 he was awarded the OBE, which was scant recognition of his contribution to his discipline. His service to general practice and the College was immense and his dedication to the long journeys from Dundee to Prince's Gate was a large price to pay. Although he made no single dramatic contribution to change and development he helped to keep the College on an even keel and allowed it to grow and mature. He was an excellent Chairman of Council and an excellent President. He should be remembered with both gratitude and affection.

James McCormick

david tovey

Tabloids

A WOMAN was talking on the radio about her experience of working at a cinema. She complained about being invisible, being treated, at best, as though she wasn't there. Of people being unacceptably rude and dismissive. One of her colleagues had found an enterprising method of reprisal that involved scraping a scaling skin complaint into the worst offenders' popcorn. Apocryphal or not, I resolved to remember a winning smile and generous eye contact next time I go to the movies.

This heartwarming story therefore exemplifies that dealing with the public has its moments, but this cannot excuse the level of boorish, self-righteous vitriol that characterises the pages of the GP tabloids.

I know that no self-respecting reader of the *BJGP* ever so much as removes the GP tabloids from their wrapping (whatever counter-claim the editor of *Doctor* magazine cares to make), but I must admit to having read at least three copies of the aforementioned magazine at some time and admit, pardon my naivety, to being frankly appalled.

First off was Dr Tony Copperfield, who recounted over several hundred words his contempt for a section of his patients and claimed, let us hope dishonestly, that he had asked, apropos of nothing, someone presenting with an ingrowing toenail when she (surprising choice of gender, not) had last had sex.

Then, as readers reached for the razor blade — or I suppose, doubled up laughing at the wit of the man — we turned to someone else, whose name I forget, but whose given task, it appeared, was to reflect Dr C as a caring, sharing, thinking liberal. This next piece started with the words 'I have recently met a monster' (I haven't checked this either but my memory is not far out). It went on to describe a single patient encounter. You can imagine the rest, but only if you are prepared to imagine someone with the empathy of Margaret Thatcher choosing (I presume it is still a choice, even in Essex) to become a GP.

Therein lies the rub. Look, I think general practice is as difficult and trying as the next person does. It is hard, busy, draining. But if the best way we can find to amuse and inform ourselves is to swap indignant, unfunny, patient-hating anecdotes, we are in very bad way.

The question deserves to be asked. What was it that led these people to choose a career in medicine? Surely neither the money, nor a desire to do good, since they moan constantly about the first and trumpet their contempt for anything that smacks of compassion.

Not difficult to anticipate the riposte. Have I no sense of humour? Don't I understand that it is all in jest? If I don't like this stuff why read it? Betcha Tony Copperfield, like Eminem, is just an old softy at heart. Well, yes, yes and no, but not necessarily in that order.

Apart from the primary crime of boorishness, this view of life is malign, corrosive. Like the spiel of drug reps it has the potential to ooze into our consciousness if we choose to let it. There is a damaging sense of victimhood — powerless, misunderstood, persecuted. It is the stem that leads otherwise sensible people to argue that GPs alone in the NHS, in society, probably in the world, should not only be paid extra to submit to being appraised but also that this should stand entirely separate from performance management. A proposal which, if advanced by a practice manager, nurse, consultant or even the cleaner, God help us, would rightly be laughed out of court.

This rabid but gathering mainstream cynicism ignores the vast majority of patients who stand in line, accept the systemic NHS stupidities, and are eternally grateful, even when they have no reason to be so. It ignores the appalling lives many of our patients lead, the employment conditions the private sector appears to regard as consistent with the new millennium rather than the one before last. It ignores the fact that, compared with most NHS managers, busy re-applying for their jobs for the *n*th time, we have nothing, absolutely nothing, to sound so embittered about.

If the moaning is simply a negotiating ploy, then I will admit it has its uses even if one imagines that it will not be forever before someone cries wolf. If these people really feel as hard done by as they claim, I hope I do not cause offence when I suggest that they should start re-taking the tablets. And let us pray that no-one at the *Daily Mail* finds out that NHS money, at the rate of up to £1000 a throw, is being spent on appraising GPs.

THE history of general practice has involved a different career structure to other clinical specialties, and its clinical academic careers pathways have until recently been equally eccentric.

Not many GPs do research, and not many GPs know what an academic career in general practice entails: historically, many GPs have perceived 'academic' as a dubious word, denoting irrelevance and ivory towers.

Yet doing research is stimulating, and indeed can be fun! The thrill of the chase through literature and data is somewhat like the excitement of making a diagnosis, but it lasts longer and is less risky. The precision required in research design, writing up results, and oral debate is an intellectual challenge that makes a valuable counterbalance to the uncertainties of data collection and the managed chaos of clinical practice.

It is also visibly productive: research is crucial to establishing the evidence base for clinical practice, and thus for improved patient care. Primary care researchers in universities re-focus research questions onto common and under-explored areas of clinical and societal concern, and enhance access to that majority of patients and NHS staff who are based in the community. We also bring breadth of perspective: at least a quarter of the members of academic departments of primary care in the UK are from social (rather than biological) sciences backgrounds, and most departments include staff with a clinical background in disciplines other than general practice.

The results of the 2001 Research Assessment Exercise for departments of general practice and primary care showed most achieving research of national and international importance within a decade of their foundation. The number of primary care practitioners undertaking higher degrees — a recognised route of acquiring academic competencies — has accelerated exponentially over time, reflecting the increased interest of primary care staff in taking up academic opportunities as a normal part of a service career.[1]

The educational function of academics in primary care is also crucial: with curricular reform for the health professions favouring a community-oriented approach,[2] they increasingly contribute to many levels of training, including research skill courses, taught Masters, and higher degrees. The NHS looks to us to underpin the development of the 'research skill-set' (critical enquiry, evidence-based practice), which enhances the intellectual rigour and the quality of care given by primary care practitioners.

This explosion of research and educational activity, and some of the consequent difficulties, have been recently documented.[3] A series of major policies in the late 1990s set out key strategic areas for clinical and health services research in primary care, made the case for an enhanced investment in research and development resources for primary care, and developed a more robust model of career pathways. Earmarked funding was made available; for England, this was primarily through a 'National Primary Care Award Scheme', which put in place three types of award appropriate to different stages of an academic career.

However, the absolute capacity in primary care remains small for the burgeoning constituency of primary care. The 55 national awards given over four years is an average of fewer than two per university medical school. Since a major NHS reorganisation of regional and national functions in 2000, the new picture of national R&D funding has remained at the outline stage, with many practitioners who had hoped to secure regional or national funding unable to find suitable resources. Academic career paths are not being sustained: a recent follow-up study of academic primary care units suggest that career progression has occurred at senior lecturer and professorial level, but entry grade posts, such as clinical lecturers, have in relative terms *declined* in number.[4] This may be a result of the 'triple jeopardy'[5] to the academic doctor's success, where there is a direct conflict between service and educational commitments and the need to be research productive.

It is also worth noting that, in the Council for Heads of Medical Schools' survey,[6]

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academic departments of general practice ranked eighth or lower in the absolute numbers of academic posts available across specialties (physicians, incidentally, consistently being first): this in spite of the fact that almost half of those practising medicine in the UK are general practitioners. Primary care, because of its dispersed and multidisciplinary service network, diverse research topics, and substantive undergraduate input in most medical schools, may find itself uniquely stretched unless this imbalance is rapidly redressed.

If there are problems for those wishing to establish clinical academic careers, how does the current picture stand to change over the next period?

Firstly, all clinical academics have to contend with financial uncertainties and the difficulties of maintaining an appropriate balance between service, administration, education and research — all too often in that order![7] Adequate protected time for research activity is essential if clinicians are going to be eligible for academic promotion and commit themselves to an academic career,[8] and the conditions for this must fit with the employment practices of primary care. Primary care academics face inflexibility in the regulations governing GP principalship, which are also contributing to losses from the service,[9] and these make career mobility difficult.

The new GP Contract, while likely to increase net investment in general practice, holds no guarantee that clinical academic salary scales will show a parallel rise: this will exacerbate the existing gap between income as a GP academic and a GP principal (a university clinical lecturer scale is typically less than £30 000 a year), and will act as a disincentive for those wishing to move across into academic roles, even on a part-time or temporary basis.

Nor do GP academics enjoy automatic access to the right to earn discretionary points or qualify for merit awards, as do other clinical specialists, both in the NHS and higher education. Thus academic GPs are victims of a financial double whammy — serving two employers (university and NHS), with responsibilities to both but the rights of neither.

Finally, the political and contextual factors that influence the ways in which academic units work are often unstable. The following are three examples that are having a substantial impact on academic primary care units and research active practitioners in the UK:

- Changes in the organisation of NHS managerial structures,[10] leading to a considerable period of 'planning blight' where national and regional funding schemes are frozen and there is diversion of monies from R&D budgets into patient care initiatives.
- A tendency for national and international funders to favour large scale established collaborations working on specific service priorities.[11]
- A re-emergence of historic hierarchies, where powerful professional leaders are reluctant to champion primary care contributions to education and research.[12]
- Lack of a clear academic career structure, insufficient options in the vocational training schemes to combine research and clinical service, prolonged job insecurity, and a lack of equity of opportunity with other disciplines.

With the redevelopments of training under the Postgraduate Medical Education and Training Board, the 'different' nature of GP postgraduate training needs attentive and motivated championing to ensure that suitable opportunities are not omitted from future policies. A continuing programme of community-based clinical and health services research is required to ensure that we deliver high-quality care in a constantly changing health system. Momentum had been built up to interest, engage, and develop both the 'dabblers' and the leading-edge clinical academics within a primary care-led NHS, and UK primary care now has a globally acknowledged academic track record. It is crucial to build on this success, rather than see its fruits wither on the vine for lack of continuing nourishment.

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On the natural history of destruction
WG Sebald (translated by Anthea Bell)
Hamish Hamilton, 2003
HB, 205pp £16.99 0 24114126 5

A YEAR ago, 'Germany's conscience' and grand old man of letters Günter Grass published his boldest novel in years. *Crabwalk* tells the story of the sinking of the Wilhelm Gustloff, a converted liner, by a Soviet torpedo in January 1945. Crammed with refugees fleeing the advancing Red Army, some 9000 people, many of them women and children, lost their lives in the Baltic, making it the worst maritime disaster ever. But Grass's book has a wider remit: it touches not just on the fate of refugees, such as those of the Wilhelm Gustloff, but on the almost entirely repressed memory of the millions of 'Vertriebene' (expellees) driven from their homes in the east. Hitler's legacy was double: not only the mass murder of the Jews but the destruction of ethnic German life outside of Germany. The end of the war saw the largest refugee flow in European history: during 1944–1945, five million Germans fled the advancing Red Army; between 1945–1948 another seven million were driven out of their ancestral homes in Poland, Czechoslovakia, Romania, Yugoslavia, and Hungary.

Grass is the first left-winger to touch on what is claimed to be a taboo theme, or one that until recently had been identified with old Nazis and 'Ewiggestrigen' (reactionaries). Later in the year, the independent historian Jörg Friedrich published his 600-page work *Der Brand* (The Blaze), a detailed and unsparing account of the fate of civilians caught in the Allied bombing. As the economy that absorbed so much German energy after the war heads for deep depression, Friedrich's book seems to have caught a new mood in the country: it has been in the bestseller lists for months, and parts of it were serialised in the right-wing tabloid *Das Bild*. At the same time as he was voted man of the century in Britain, Winston Churchill stood accused in Germany of a deliberate policy of airborne terror against civilians, and was even called a war criminal in *Das Bild*'s editorial pages. In 1997, well before Friedrich's book, WG Sebald gave a series of four lectures in Zürich on the air war in Germany (and thereby goaded Günter Grass into writing *Crabwalk*). Born in southern Germany in 1944, Sebald came as a lecturer to Manchester in 1966, and eventually ended up as Professor of European Literature at the University of East Anglia. After a number of quite conventional academic monographs in German, he published four books in the 1990s that, in English translation, made him world famous. *Vertigo*, *The Emigrants*, *The Rings of Saturn* and *Austerlitz* are part-memoir, part-travelogue, part-phantasmagoria, and go under the generic term 'novel', it would seem, largely for convenience's sake: in an interview Sebald himself called the last 'a prose book of indefinite form'. Grainy black-and-white photographs punctuate the text, signposts on a journey through limbo. His books are like the coast of East Anglia that he knew so well; forever slipping away from exact definition. Sebald was killed in a car crash near Norwich in December 2001.

All four of Sebald's novels touch on the aftermath of the nightmare history of the first half of the 20th century. But one issue obsesses him in *On The Natural History of Destruction*, a transcript of his Zürich lectures (published in German under the neutral title *Airwar and Literature*) that is supplemented by three essays on German-language writers: why has so little been written about the destruction of Germany, in which 131 towns and cities were levelled to the ground, and the Royal Air Force alone dropped one million tons of bombs? Why was there no great literary epic of the total degradation? As a child born towards the end of the war, Sebald grew up with almost no sense of what had happened to his country. The war was a terrible family secret. The vanquished were failed candidates for domination, and they knew it: their late Führer had actually called down destruction upon them. And 8.5 million of them had been members of the Nazi Party. As the term suggests, Zero Hour was intended to draw a blank over a deeply humiliating and shameful past: 'The destruction … is reflected in works written after 1945 by a self-imposed silence, an absence also typical of other areas of discourse, from family conversations to historical writings.' He wonders which did more to obliterate German history: the bombing of medieval cities or the wilful erasure of memory.

In short, Sebald asks questions that a historian is not permitted to ask because they are metaphysical. But that doesn't mean the history should be sloppy. For one thing, German writers did write about apocalypse, or at least about its evil tidings. Written in exile, Thomas Mann's *Doctor Faustus* (1947) brings German history up to date with its *Götterdämmerung* in words as fierce as any prophet's: 'What will it be like to belong to a nation whose history bore this gruesome fiasco within it, a nation that has driven itself mad, gone psychologically bankrupt … a nation that cannot show its

face?' Events had measured up to the wildest eschatological forecasts in a society that, as Norman Cohn showed in *The Pursuit of the Millennium* (1952), was not short on lurid imaginings. One novel written about the horror of the bombing, Heinrich Böll's *The Stone Angel*, remained unpublished until 1992. Other writers — Bernhard, Koeppen and Hofmann spring to mind — wrote obsessively about the war, if not about the air war. Yet despite their work, and that of local and amateur war historians, the horrifying chapter, according to Sebald, 'never really crossed the threshold of the national consciousness'.

Horror there was. The firestorm raid on Hamburg on 27 July 1943, codenamed Operation Gomorrah (a revealingly cynical cold joke) in which the RAF dropped 10 000 tons of high explosive and incendiary bombs on Hamburg, was a non-nuclear forerunner of the bomb on Hiroshima. 'The fire, now rising 2000 metres into the sky, snatched oxygen to itself so violently that the air currents reached hurricane force, resonating like mighty organs with all their stops pulled out at once. 'Fifty thousand people died (more than were killed by German bombing of Britain during the entire war). Glass melted, people asphyxiated in their cellars, and anyone who tried to make a run for it sank into boiling asphalt outside. (It was RAF policy to concentrate bombing in working-class areas in order to minimise casualties in the air and maximise them on the ground, although these areas, especially in Hamburg, were the heart of anti-Nazi resistance in Germany.) More than a million people fled the city, some of them unhinged by their experience. Sebald describes a woman's cardboard suitcase bursting open in the rush for a train and her carbonised baby falling out along with toys and a manicure case, a relic of a past that had been intact a few days previously.

But what does Sebald mean by the 'natural history of destruction'? The phrase, he reveals, comes from Solly Zuckerman, whom he interviewed in the 1980s. Research anatomist turned weapons adviser, Zuckerman visited Cologne in 1947 (which had 31.1 cubic metres of rubble per inhabitant) intending to write an article under that title for Cyril Connolly's magazine *Horizon*. He was unable to summon any adequate words to describe what he had seen. So it wasn't just a German phenomenon. 'How ought such a natural history of destruction to begin?' asks Sebald. 'With a summary of the technical, organisational and political prerequisites for carrying out large-scale air raids? With a scientific account of the previously unknown phenomenon of the firestorms? With a pathographical record of typical modes of death, or with behaviourist studies of the instincts of flight and homecoming?' Familiar to all doctors, the phrase 'a natural history' gives warfare an ineluctable quality, one that puts it beyond human control. Indeed, his bleak conclusion to his book supports that contention: 'Our species is unable to learn from its mistakes.'

Just what is natural about the history of destruction? Before contemporary warfare, only an earthquake could annihilate so many lives in such a short time. In the First World War, 5% of deaths were civilian; by 1939–1945 the proportion had risen to 65%. If anything, Sebald's book fails to present its moral case properly. The bombing of Germany was not an earthquake; it was an intentional act. Goebbels promised total war; the Allies were willing to stretch the rules of war to include the mass killing of civilians — neither enters Sebald's search for explanation. Sven Lindqvist's labyrinthine *A History of Bombing* (2000) offers a more compelling look at the 20th century's cold psychology of killing at a distance, in which the protest against the technical radicalism of bombing made by Bishop of Chichester, George Bell in the House of Lords in 1944 still retains its force: 'What we do in war — which, after all, lasts a comparatively short time — affects the whole character of peace, which covers a much longer period'. Sebald offers glimpses of an enormous historical catastrophe: it is like looking down on one of those tormented and weirdly lit landscapes by Albrecht Altdorfer that hold such a fascination for him.

But the catastrophe is a spectacle. That is why his book fails as history: it lacks proper context and causes. Wishing to see the sufferings of the Germans (eliding the industrialised extermination of the Jews, which became more frenzied as the regime collapsed) as part of a larger pattern of pain that defines the human condition, he provides no understanding of the unnatural history of destruction. Against its better intentions his book swells a contemporary mood in which the victim's cause is the only good one.

Iain Bamforth

Stories of Sickness (2nd Edition)
Howard Brody
Oxford University Press, 2003. PB, 295pp, £22.95, 0 19515140 2
Stories Matter: the role of narrative in medical ethics
Rita Charon, Martha Montello
Routledge, New York, 2002. PB, 240pp, £24.95, 0 41592838 9
Medicine and Art
Emery AEH, Emery MLH
Royal Society of Medicine Press, London, 2003. PB, 100pp, £40, 1 85315501 2

STORY and narrative are at the centre of human understanding, memory systems, and communication. Memories and information are not just stored; they are 'storied'. Medicine and health care's foundations are built out of stories: brought by patients, constructed by patients and clinicians together, communicated between physicians (such as referrals) and, vitally, told by educators.

If our lives weren't constantly told and retold, 'storying' each new experience, we would have no coherent notion of who we are, where we are going, what we believe, what we want, and where we belong. The stories of the people with whom you share experiences may vary hugely from yours. Because no story tells the facts. All they can tell is experience.

Patients tell and show you their illness story: with speech, body language, and examination and tests. You learn how illness has disrupted the habitual story of their lives and possibly broken their hopes and dreams; this discontinuity and loss is often a key to much of their suffering. They request help in fixing their broken story. And you listen carefully, make sense of their story fragments in the light of your own personal and professional experience, knowledge, and expertise. They don't give facts; you are not able to interpret what they say and turn it into objective truth. You create your own story of their suffering, their pain. You share this with them and hopefully, sensitively, co-construct a helpful clinical story; you may also support them to create more healing stories of their own lives.

You similarly listen to colleagues. You listen critically, creating or enhancing your own story, and to make sense of the way these stories mesh and interact with each other.

You use narrative competence to disentangle the ethical issues that arise continuously within and from these stories. For the stories that are created by and around us, are not only the stuff of diagnosis, of prognosis, the basis for treatment and care decisions. The Oxford English Dictionary calls ethics 'a study of human duty'. This duty is associated with the everyday actions of ordinary people — you and me — patients, physicians, nurses: told and understood in our stories.

Stories are always from a point of view, even (or especially) those claiming to be objective. It is essential to listen empathically for whose point of view is being expressed, the role of each narrator and the way it affects the ethical understandings inherent in the story, the kind of dialogues that have taken place between the intertwined narrative voices, and the reliability of each narrator. This is thinking *with* stories, rather than thinking *about* stories.[1]

And how is the skill to listen properly and make sense acquired? How do you develop your ability to tease out ethical issues from the complex mesh of your own, your colleagues', and your patients' stories? How does a doctor acquire narrative competence, and ethical skill and compassion?

You started with understanding stories that began 'once upon a time ...'. And you practiced by reading, and by focusing critically on the stories you share and create in practice, and possibly by writing.

The practice of primary care involves uncertainty, dilemma, and ambiguity. Patients' experience is similar: constructed into stories from different points of view. 'Stories are at the heart of clinical practice ... they allow us to explore areas which are tentative, uncertain, and even heretical.'[2] Effective working stories — whether by Dostoyevsky, or told over coffee — concern ethical uncertainty, dilemma or ambiguity, encountered and tackled by the characters. If you can critically focus upon the stories narrated from the point of view of each of the major characters, you provide yourself with the most powerful basis for ethical understanding and judgement.

You learn narrative competence by reading. Literature offers a wealth of experience of, and enquiry into, the human condition. The best kind of literature sets up ethical ambiguities and offers direction towards resolution; it provides the story structure to enable you to tussle with the issue — some sort of beginning, middle and end. It provides no solutions to ethical dilemmas — that's your job. The reading of literature is a process of 'as if'. If I were this character or that, what would I feel think, and ethically do? So as you read you sharpen your ethical wits, weighing and judging, developing and refining your own personal values: what is the right decision here — right according to what you think your own principles and values are. You do this with the help and guidance of our best thinkers, because they are the writers of our best literature — Sartre, Woolf, Dostoyevsky, Sophocles, Kafka.

Narrative and ethical awareness and competence is also learned and developed by exploring stories of practice in writing.[3] Understanding, learning and compassion are also developed by art - pictures of stories; the book by Emery is beautiful and functional: use it. Brody's and Charon and Montello's books are both an exciting read — clearly explicating the role of story in medical and healthcare practice, and particularly in ethics. They both have transformative power: read them if you are ready to change and develop.

Gillie Bolton

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Leaves from the life of a country doctor
Clement Bryce Gunn
Birlinn, Edinburgh, 2002
PB, 195pp, £7.99 (1 84158238 7)

DR Clement Bryce Gunn set up his plate in the border town of Peebles towards the end of the 19th century and recorded this fascinating series of soundbites of professional experiences. After waiting weeks for his first patient, a colleague offered him a partnership and died almost immediately, catapulting him into practice in a town, referred to in the foreword by his friend, John Buchan, with the words of Mungo Park: 'I would rather return to Africa than practise again in Peebles'. Regular nocturnal expeditions through snow to maternity cases sound frightful, yet Gunn's work–life balance nonetheless enabled him to indulge his hobby as an antiquary — in which he achieved some distinction. His almost casual description of amputating the limbs of the elderly, and oblique reference to leaving some chloroform 'for euthanasia' in the house of a fine eight-year-old boy choking from diphtheria, remind us that in its early days, our profession was not for the faint-hearted. Yet the call at 2.00 am from a patient suffering from the effects of fried eggs, his delight at 'curing' a hopeless neurotic with bread pills and getting rumbled for prescribing paraffin for another, remind us that perhaps our lives have not changed that much!

One is struck throughout by Dr Gunn's feeling for history — and his place in it. He muses at what readers will think of his journeys on horseback, while embracing 'new' technology, such as the telephone and motorcar — yet also discarding it when he realised that nobody else has a phone except the pharmacist, and substituting this with a private line. He was well connected, studying alongside Conan Doyle at Edinburgh, where he was also taught by the model for Holmes. One cannot imagine a modern GP being honoured with his home town's freedom on the same platform as Earl Haig, but Gunn carried considerable personal responsibility for townspeople's lives — it was to he that people applied to enter the poorhouse and the asylum, and his house provided the parties to entertain poor children. And his effective use of this influence is illustrated when he organised a rota of neighbours to provide community support to an exhausted woman outworker. No endless calls to social services — he just asked them to do it and they did! If you are thinking about ideal holiday reading material, you should not miss the countless other anecdotes of this slim volume.

Jim Ford

roger neighbour - behind the lines

On words

'WHAT'S in a name?' asked the Bard of Avon (whose own name, you'll recall, was Shake-speare, not Wobble-spike, or even Wag-staff.) 'That which we call a rose,' he asserted, 'by any other name would smell as sweet.'

Possibly, and possibly not. Some early botanist, coming at it cold, might have chanced upon a previously unknown and unnamed species, breathed its dreamy fragrance, and exclaimed, 'Ah sweet flower, I shall call thee zose.' And since the word 'zose' stood for nothing pre-existing, he might have got away with it. If my flower-beds were full of zoses, not roses, I'd be with Shakespeare and not give a fig for what particular syllables we used to refer to them. But had that long-dead bestower of names lit instead upon the word 'sprout', or 'belch' ... you get my drift. The scent molecules hitting my olfactory epithelium might be the same, but tell me what I'm smelling is a sprout and I suspect the edge will be taken off my enchantment. What P G Wodehouse called 'the psychology of the individual' is at work. It doesn't matter what you call something, as long as what you call it doesn't have conflicting associations. But if it does, the name alters the experience.

Take another case in point: the word 'tup', another of Shakespeare's favourites. You might recall over a year back I told you of the blue-bottomed sheep of Dumfries, whose newly-serviced sisters bore the tell-tale badge of deflowerment transferred from the blue-painted bellies of the rams (or 'tups') who had obliged ('tupped') them under cover of darkness. Now, veterinary sources confirm that tupping occupies less than 1% of a ram's working day, the rest being equally divided between eating grass and devising a proof of Fermat's Last Theorem. But note the usage; when 'tup' makes the transition from noun to verb, only one small part of the animal's skills repertoire is emphasised, and that salaciously. And so when, in *Othello*, Iago tells Desdemona's father that 'an old Blacke Ram is tupping your White Ewe', he does not mean that the lovers are to be found, chalk in hand, at the blackboard of the Maths Faculty in the University of Venice. By the same token, we might regret how the honourable noun 'doctor', in spawning the verb 'to doctor', risks being contaminated with hints of falsification and adulteration.

Sometimes, moreover, words will, like boomerangs, turn back on themselves in mid-flight and, ungratefully and disloyally, injure the innocence of their origin. Thus: the man whose wife is adulterously tupped himself becomes a tup, the word (in a salt-in-wound kind of way) now coming to mean a cuckold, smearing the victim with the verbal overtones of the crime itself. Is general practice still a craft? Not if it implies we are crafty. A profession, then? Not if, as Illich insisted, to professionalise medicine is to conspire to disempower our patients. If thrown mud sticks, who would be a potter?

And it doesn't end there. You might also recall how, following my 'sheep' piece, I was chided by a correspondent for making play with his wife's maiden name, Tupp. He threatened to have me tupped (which, I learned to my relief, meant arrested, not sodomised) by the bogeys (meaning police, not nasal crusts). Luckily we never met face to face. Had we done so, I'd not have given tuppence for my chances in a fist fight. (That's tuppence as in two old pennies, not, as you might have thought, the cost of hiring a ram on an overnight basis.)

Forgive me; I apostrophise. (That's apostrophise as in addressing you rhetorically and in brackets, not as in forming plural's like greengrocers's.) But something deadly serious underlies these admittedly enjoyable jugglings with words.

As I write, we are at war with Iraq, and the proposed new GMS contract has run aground on the rocks of the Carr–Hill formula. Words like 'moral' (as in moral high ground) or 'united' (as in United Nations), words like 'quality' (as in quality indicators) or 'opportunity' (as in earnings opportunity) are squirming to preserve any vestige of their original purity of meaning. What are we to make of it? Simply, inevitably, regrettably this; words, surreptitiously hijacked and ruthlessly wielded, are weapons of mass deception.

So let us be clear. In the context of our own unashamedly professional endeavours, and despite the obfuscations of our politicians, posturing is not the same as policy. Activity is not the same as action. Exhaustion is not the same as achievement. Protocols, guidelines and formulae are not the same as wisdom. And — as any dancing bear will tell you — new chains do not a new contract make.

March UK Council

The new General Medical Services Contract

Council had an interesting, wide-ranging and detailed discussion about the new GMS Contract. Members of Council were given an analysis of the College's input into the development of the new Contract to date, and the negotiators' generally positive responses to the comments that Council made on the consultation document last year. The Chairman, Professor David Haslam, highlighted the potential challenges and benefits to the College following either the acceptance or rejection of the new Contract proposals. David emphasised that it was not the role of the College to advise on how to vote on the Contract, but would be urging members to exercise their vote. Many points came out of the discussions at Council, and a great deal of concern was expressed about the initial calculations that Council members had made on their own practices, typically showing a reduction in income. Other specific topics of concern included the issue of academic GPs and the potential widening of the salary gap with practising GPs, and also that of equity and the problems the new Contract could cause in financially penalising good practice carried out in inner-city practices.

The outcome of the debate was support for a statement from the College welcoming the quality emphasis in the new Contract and linking these to the values of the College. David Haslam will also stress the need to address the issues around academic GPs and the other areas raised about equity and continuity of care.

Since Council discussed this topic, the ballot on the Contract has been suspended, pending the resolution of anomalies arising from the formula being used. A College statement on the Contract will be put on hold until the situation becomes clearer.

Revalidation, appraisal and the implications for Accredited Professional Development

Another major area of discussion for Council was on the latest developments with regard to revalidation. David Haslam introduced this item and reported on his attendance at a recent GMC stakeholders meeting on revalidation. At this it was made clear that the submission of the summaries of five appraisals will be sufficient evidence for revalidation. This has caused some concern as it was always the understanding of the College that patient safety and fitness to practise were fundamental elements of revalidation. The GMC now stresses that local clinical governance procedures are the main tool for detecting poor performance. Among the areas of continuing concern for the College was the reliance on appraisal (which is a formative and educational process) for revalidation (which is essentially a summative process). In linking so closely appraisal to revalidation, it may risk damaging the appraisal process. Concern was also expressed about the lack of patient involvement in the revalidation process.

The issue of non-principals and their revalidation also remains to be resolved. We have also been seeking details about what quality assurance mechanisms will be put in place. These issues have been raised with Professor Sir Graeme Catto, the President of the General Medical Council. The GMC is due to publish its guidance in the *Licence to Practise and Revalidation for Doctors* in early April and Council had the opportunity of seeing the final draft of this document. David Haslam reported that he had been able to ensure several changes to the draft before it is published.

Linking in with the discussions on this topic, a motion from Tamar Faculty was also considered. The motion asked the Officers of Council to explore the feasibility of recertification of the MRCGP examination. The purpose of the motion was to establish the principle that this qualification is not held in perpetuity.

Dr Has Joshi also spoke on the future of Accredited Professional Development (APD) in light of the way that revalidation has now developed. Following a review of APD, this would be refocused as it was felt that it was too complex for the current requirements of revalidation. A smaller, modular based framework was being developed, similar in set up to Quality Team Development (QTD).

The outcome of the discussions is that David Haslam will express the College's disappointment with the current proposals for revalidation to the President of the GMC. A joint letter will be sent from the RCGP and the GPC following the launch of the GMC's guidance on a licence to practise and revalidation emphasising the use of Good Medical Practice for General Practitioners and the quality award tools that the College has available. Support was expressed for the Tamar Faculty motion and the need to clarify and simplify our own quality awards.

Clifford Ayling Inquiry

I gave a report to Council on the College's response to the private inquiry into how the NHS handled allegations about the performance and conduct of Clifford Ayling. Much of the evidence we presented was similar to that provided for the Shipman Inquiry, as it dealt with complaints, especially around concerns raised by colleagues. The other area of particular interest to the Inquiry is the use of chaperones by GPs and hospital doctors when conducting intimate examinations. In preparing our response, it became apparent

that there is little guidance for doctors in this area. We have asked the Patient Partnership Group (PPG) to look at the issue from a patient perspective, and their initial deliberations have highlighted that this is a complex issue with no easy answers. Dr Orest Mulka of the Leicester Faculty has agreed to lead on developing work on producing guidance about the use of chaperones. The initial thoughts of PPG will be fed into this process.

Undisclosed payments to doctors recruiting patients in clinical trials
The Chairman of the Committee on Medical Ethics, Dr Iona Heath, put forward a recommendation to Council that payments made to doctors who enter their patients in clinical trials be included in the information given to patients. After discussion Council approved the following:

Full details of any payments made to doctors or other clinicians who recruit patients into trials should be included in the information given to the patients, including details of the amounts involved and an explanation of those amounts.

The Leadership Programme
Professor Aly Rashid attended Council to give feedback on the first year of the Leadership Programme. We were all pleased to learn that the programme has generated enthusiastic feedback from the participants. All twelve places have been taken up on the full programme. However, there are still four places available on the next masterclass session on 30 May. The subject for this masterclass will be The Political Context and the Formulation of Health Policy. Council members were asked to draw this to colleagues' attention. If anyone is interested in attending or they want to know more about the Leadership Programme, they can phone Aly on 0116 201 3958 or e-mail at jcurtis@dmu.ac.uk

Council and Committee Vacancies
Following the resignation of Dr Douglas Garvie, Council approved the appointment of Dr Colin Hunter as the Council Director of the RCGP Superannuation Fund Trust Company with immediate effect.

I also announced to Council that Dr Joe Neary will be the Medical Vice-Chairman of the College's Patient Partnership Group. Joe will replace Dr John Dracass, whose term of office has now ended.

If you would like any further information about the foregoing items or information about other business discussed at Council, then please do not hesitate to get in touch with me through honsec@rcgp.org.uk. The next meeting of Council is on Saturday 14 June 2003.

Maureen Baker

neville goodman

Cholesterol and the offside trap

FOOTBALL is part of me, but I don't give advice about it. I'm a doctor; I give advice about medicine. I'm pretty careful, too. These days it doesn't do to give advice outside one's field of expertise. There was a time when relatives would sidle up with their children and ask me about rashes. As a child-free anaesthetist who skipped out on dermatology at medical school because going to the clinics meant catching two infrequent buses, I freely admit ignorance.

Football is part of me because of primary school, in Manchester. I was a very little boy when I was a little boy. At breaktime in winter, gangs of boys would roam the playground asking, 'Who do you support: City or United?' As far as I'm aware there was no Catholic/Protestant divide between boys who supported one or the other, although that was certainly true of the teams at the time. In Glasgow, the similar Rangers/Celtic divide could not be avoided by pleading atheism; in Glasgow you had to choose Catholic atheist or Protestant atheist. These factors never mattered at Gatley Primary School: it was a simply City or United. The wrong answer meant physical assault and, as a very small boy, I soon learned that United supporters in general were bigger. So they hit harder. I became a United supporter by pragmatism, but have remained so despite little physical abuse occurring in the circles in which I now move.

Liverpool has a similar schism. I spent a brief, pleasant, and instructive month at Alder Hey as a registrar, when I learned that an unfailing way to distract children (boys or girls) from needles and other unpleasantness was to profess allegiance to whichever team the child didn't support.

Leeds has only one team, but they had 'our Bobby' Charlton's older brother, Jacky. He knows a good deal about football, and a fair amount about something I know nothing of — fishing. He's not much in the limelight now, but I would accept advice from him on either subject. His knowledge of the offside trap and the best place to catch perch are probably second to none, but I have in front of me a Flora-activ packet. On it, a very young-looking Jacky is kicking a football and saying, not 'This stuff really does me heart good!', but 'My LDL cholesterol dropped by 11%.' The threat of direct-to-consumer advertising has receded somewhat after a parliamentary vote. If it returns, prepare for Big Pharma's bids for famous people much more in the limelight than 'our Jacky' to sell their drugs.

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our contributors

Iain Bamforth lives in Strasbourg and is preparing a collection of essays on literature and medicine

Gillie Bolton is a research fellow, and edits the poetry pages for *Progress in Palliative Care* (carers of the dying) — poets can submit appropriate work addressed to Gillie Bolton at: The University of Sheffield, Institute of General Practice and Primary Care, Community Sciences Centre, Northern General Hospital, Herries Road, Sheffield S5 7AU

Yvonne Carter is Professor of General Practice and Primary Care and Head of Department at Barts and The London, Queen Mary's School of Medicine and Dentistry, University of London

Jim Ford was a GP, then became a civil servant and is now an occupational health physician at a shipyard and two nuclear power stations in the northwest with Wellwork Ltd

Amanda Howe is Professor of Primary Care at the University of East Anglia in Norwich and currently chairs the RCGP Research Group

Seth Jenkinson is a general practitioner at Mixenden Stones Surgery, Halifax, Yorkshire, although he is currently residing in Ecuador

Una Macleod is a lecturer in general practice in the University of Glasgow Section of General Practice and Primary Care

James McCormick is Emeritus Professor of General Practice in the Department of Community Health and General Practice, Trinity College, Dublin

Saul Miller is a GP in Belford, Northumberland

Graham Smith is a research fellow and oral historian at the University of Glasgow Section of General Practice and Primary Care

David Tovey is a GP in West Dulwich, London

saul miller

Mysteries

THERE are many mysterious forces at work in our lives. The district valuer is not often thought to be one of them but I contend that this is the case.

Out canoeing today I came across many examples: a still patch in the midst of the wind-ruffled river; buzzards swooping and circling around a bare patch of meadow; half a sandwich vanished from under my nose and yet the dog heard nothing. I think that when you slow your pace of being, open your senses to the world, more and more such examples become apparent. Of course, many such inexplicable phenomena only loosely affect us personally — or appear to, anyway.

The district valuer is a different kettle of fish. He is someone I know exists but whom I personally have never sighted. On reflection, I am not even certain I know anyone who has seen him for sure. Which I, at least, find a little uncomfortable, because he knows us well enough to have decided how much rent we should be paid for using our building for NHS work.

What is inexplicable to me is the variety of ways in which he knows others and they know him. Something like the phenomenon of the one-way mathematical equation, in which knowing the method and the outcome is not sufficient for establishing the input. Or maybe more like the Theory of Relativity as it applies to the distortion of time and space, so that those things we normally take to be fixed and certain suddenly become contingent, dependent on who is asking to know, and from where. Yes, something like that.

It started with the idea that we needed to extend our premises and the discovery that these days there are in fact two options: the Cost Rent Scheme and the Private Finance Initiative (popularly known as PFI). Cost Rent has a lot to be said for it except that our Primary Care Trust was quite sure it was only worth considering for proposals that would remain in the ideas stage.

The PFI option itself turned out to allow two options, one involving a PFI company and the other involving ourselves, with the help of a hired project manager, pretending to be a PFI company. We decided to try pursuing both options simultaneously to see what we might be able to get from each.

Within a very short time we realised that there was a significant difference. On the one hand the PFI company was offering us a good deal that would result in our occupation of a whole new building that would dwarf many a cottage hospital or minor stately home. On the other hand, we would face a crippling mortgage for a few extra rooms tacked on the back of the existing building. Somewhere in the background we should have heard the spooky music.

It turns out that all hinges on the value the district valuer assigns to each square metre of developed earth. What appears inexplicable in the comparison between our two possible schemes is that the same floor appears capable of different value, depending on the scale of the overall building, almost as if there is a space–time distortion at play, a gravitational effect of larger buildings on the valuer's calculations. Or maybe the scale of the building has nothing to do with it: perhaps who is asking matters most, and from where.

When you get to here just check to make sure this really is the back page. And if so just stop to wonder whether — for someone else, somewhere else — there is more.