The Back Pages

viewpoint

The tree of possibilities

It's spring, and Inverness is basking in a tropical haze. I'm a houseman working nights at the hospital, and before duty I make an early evening excursion to the nearby site of some ancient burial cairns. The Clava Cairns are a wonderfully preserved collection of stone mounds, thought to have been built by local farming communities in the third or fourth millennium BC. The cairns are shrouded in mystery. We know little of the social organisation, culture or beliefs of their creators, except that they placed great significance on marking our exit from this world.

Sitting against a lopsided standing stone, I watch the gently swaying branches of an old birch tree, through which the sun's rays shimmer onto the cairns. Moss and lichen grow on its trunk, which reaches skyward, dividing again and again until each shoot ends in a young green leaf. To me, this tree represents the adventure of life ... its boughs reach upwards, spanning out in all directions, corresponding to the innumerable roads not yet travelled. The tree of possibilities is always there before us — but once the responsibilities of adulthood are felt it seems that life becomes increasingly restricted to a single path, and the journey is laid out before us, once and for all. Our field of vision is narrowed, steadily and imperceptibly. But travel and art feed the tree of possibilities, and with these in plentiful supply I have selected one path for more detailed exploration.

I want to be a GP, a proper family doctor. It could just be youthful idealism, but, to me, general practice seems a wonderful career option, for reasons both wholly selfish and fundamentally altruistic. The essential nature of the work — to sit in a nice room and have intimate conversations with a steady stream of interesting and varied people — seems a rare privilege. It puts us in touch with the core of existence, representing an exceptional opportunity to find out what life is all about. And to be paid large amounts of money for doing it ... how incredible! Besides this potential for personal enrichment, the work of a GP is of incontestable benefit to others — what an amazing and fortunate coincidence.

I began my pre-registration year with four months in general practice, and have since worked in hospital jobs. Hospitals scare me, right to the depths of my being. I find that I am incapable of looking squarely at death, particularly in the hospital context. Here it represents failure. In hospitals it sometimes seems that the purpose of life is simply to prolong it. Maybe it's because medicine comes to rule our lives so much that its most immediate goal transforms itself into our reason for being. We become trapped in the system, it narrows our outlook and the tree of possibilities regresses. This domination of our lives by the medical system must subtly impact on our attitudes towards patients, and I fear that it can blind us to the things that really matter.

It has been said that young doctors generally come to terms with death at an earlier stage than do other people. But what can it mean to come to terms with death? I don't think it involves getting any closer to understanding the transience of an individual existence. More likely is that we just cease to question the absolute inevitability of its end, and thus it represents an impoverishment of our lives. Paradoxically, this personal acceptance, this acknowledgement of our ultimate powerlessness, has limited impact on the efforts expended in hospitals to prevent or delay the ultimate cure for all illnesses and disabilities.

In general practice, I find that medicine can concentrate on issues of living. It's where the uncertainty that makes life interesting is acknowledged and managed, not minimised. Doctoring in hospitals is a different game; hence I feel a desperate need to maintain regular contact with general practice throughout my training, and have recently been offered an exciting opportunity to do this. A small pilot scheme is in progress in Scotland, where trainees are based in general practice for the whole duration of vocational training. Hospital experience will be gained through a series of short secondments into various specialities, decided purely according to the trainee's learning needs. It offers a stable foundation in the continuing, personal relationships of primary care, punctuated by brief and intense exposures to the supporting hospital expertise. I begin the three-year experimental scheme in August this year, and envisage that it will provide some of the most stimulating and intensely educational experiences of my life so far.

It's spring, the tree of possibilities is growing, and I have found a brand new branch to explore. The sun is still shining, though the wind has picked up, as it rustles through the canopy above. Some old twigs are dislodged and fall to the ground beside me. I get up and wander around the cairns once more, quietly preparing my mind for another night in the hospital. The work can be draining, but it is quite bearable and often enjoyable. It's probably just selfishness that drives my continual craving for the time when I can be a complete doctor, a real GP.

Graeme Walker

"There is, however, a feeling in the medical community here that something has changed, and possibly forever. Never again will doctors be so blasé about their contacts with patients, and in particular those with fever."

SARS in Hong Kong, Donald Lyon, page 508.

"Barbara Starfield is to primary care what William Harvey was to circulation ..."

John Cave at the Spring Meeting, page 510.

contents

Celtic Pilgrimage — rural WONCA 2003

In medieval times, the shrine of St James was the destination of Celtic Pilgrims, who made their way via the Bristol Channel, joining the ships of the wine trade that worked the trade route back and forth to Porto. The ships carried woollen goods on the outward leg and port on the return trip.

This year, from 24–27 September, you are invited to join the revival of the Celtic Pilgrimage to Santiago de Compostela in Spain, by attending the Sixth Rural WONCA World Health Conference, which is being held at Santiago and organised by the Spanish Rural GPs with a degree of outside help. Afterwards, there will be a clinical meeting in Braga, in Portugal, where conference themes will be continued in small group discussion.

This year's revival of the Celtic Pilgrimage will be led by Dr John Wynn-Jones (Wales), Chairman of the Scientific Committee, John Gillies (Scotland), who is chairing the new Culture section, and John A J Macleod (Scotland) as WONCA Liaison member. The programme is available for viewing on **www.ruralwonca2003.net** and registration can be done through the site. There are speakers from all over the world, including, from the UK, Richard Smith (Editor, *BMJ*) and Julian Tudor Hart (The Valleys). Numerous workshops are planned, allowing much more direct interaction than would usually take place at large international conferences. There will also be discussion on some of the WONCA policy documents and the Melbourne Manifesto.

The Spanish are renowned for their hospitality and they have a fine programme in hand to cater for all ages and tastes. A new concept for our conference is the 'Market Square', where the cultural events, with displays of artwork and photographs, will be staged. So, no need to queue for deck space on a sailing ship, just pack your bag, gather the family and make your way by car or plane to join this exciting gathering.

John A J Macleod

SARS: an unexpected experience

THE Visiting Professorship of the Hong Kong College of Family Physicians offers an overseas professor of general practice the opportunity of spending up to two weeks as a guest of the Family Medicine Unit at the University of Hong Kong. The population of Hong Kong is approximately seven million, with 90% of primary health care provided by private practitioners. Set in the midst of a largely economically deprived urban population, the Unit runs a family medicine clinic for 8000 patients at the Government Ap Lei Chau Clinic. Having looked forward to the attachment for several months, the duration of my visit was reduced by two days because of the increasing outbreak of Severe Acute Respiratory Syndrome. The Hong Kong Department of Health issued WHO guidelines to primary care physicians on the management of suspected cases on 17 March 2003 — my first day in the Unit. The guidelines focused on the symptoms and signs of SARS and when to refer. Initially, no information was given to professionals or the public about preventive measures.

Undergraduate clinical teaching was cancelled on my third day and doctors and nurses in the Unit started to wear masks at work. Colleagues increasingly feared the spread of infection in their community. As news of SARS slowly increased, it became clear that approximately half of those infected in the region were health professionals, particularly those working in hospitals where the first cases were treated. Many colleagues knew at least one healthcare worker who had been diagnosed. Perhaps for the first time in their lives, family doctors felt a threat to their own health, to their colleagues, and to the medical students they taught. They became frightened of infecting their families, and one colleague sent his children to stay with relatives in Australia, while another made arrangements not to bring a son home from boarding school in England over Easter.

Images from the war in Iraq and academic debates about the strategies employed were broadcast continually on television. Information about the incidence of SARS and news of infectivity in the community remained sparse. Initial welcoming comments were 'it was good of you to still come', when initial news of the outbreak at home had been virtually non-existent; I and my husband had travelled ignorant of any personal risk. Our hosts increasingly displayed a polite but assertive approach to rearranging our flight reservations home. Taking care of invited guests was simply adding to their worries. For two weeks after our return, regular e-mails checked on the state of our health and provided updates on confirmed cases from the community clinic. The HKCFP also celebrated its 25th anniversary with a scientific meeting during our visit. The following morning we received a telephone call to say that the Chief Executive of the Hospital Authority, who had attended the event, had been admitted to ITU with suspected SARS. A frighteningly large number of people diagnosed seemed to require early intensive care. Finally, the story made front page news (although only a paragraph), and the risk to health professionals who attended the meeting became real. We were advised that masks had been left in an envelope outside our room and were strongly advised not to travel on public transport and to avoid crowded places. Shops and restaurants were already pretty empty. Our masks were never worn. We remained sceptical of their value outside a hospital environment.

During the meeting a Fellowship Conferment Ceremony was held jointly with the Hong Kong College of Community Medicine. The Minister of Health of the People's Republic of China was one of the recipients. A colleague translated his acceptance speech as he outlined the many challenges in public health facing China, particularly the lack of health care infrastructure in rural communities. Details of the escalation of SARS in April have been accompanied by news that the Minister has been replaced. Around the world, public opinion has supported the view that the authorities were initially keen to keep the emerging epidemic hidden.

No-one questioned our fitness to travel at the airport. Other travellers and aircrew wore masks for the duration of the 12-hour flight. We witnessed two passengers receiving oxygen during the journey (one also having a nebuliser). We prayed silently that neither was infected and hoped that no-one would ask if a doctor was on board. Since then, there has been plenty of information about SARS, from editorials in the *BMJ*, *Lancet* and *New England Journal of Medicine* to an array of information on health-related websites.

The current advice is not to travel to high-risk areas. Our hosts are now our friends and although our personal fear has receded, our concerns for their welfare continue. Academic colleagues are now worried about their own travel plans and whether they will be able to fulfil promised commitments later in the year. A hospital colleague recently told of his experience of treating the second confirmed case in the UK and the need for stringent infection control. No-one knows how long this outbreak will last, but there is no obvious end in sight. As a doctor you do not expect to contract an infectious disease that might kill.

Yvonne Carter

Eighth EAPC Conference
The Hague, Netherlands

'NATIONAL and international surveys, government reports and World Health Organisation data all show that palliative services, from home-based hospice systems to hospital-based consultation teams, are inadequate to meet the growing needs of the world's population': so said Dr Kathleen Foley in the Floriani Lecture, on the first day of the Eighth Congress of the European Association of Palliative Care (EAPC) in April. Is it the case that patients with a life-threatening disease who need good care have missed the bus? No, that can't be true. In The Netherlands, policies that the government have pursued for the past five years have focused on encouraging programmes for better facilities in palliative care, adapted to the needs of patients and their environment.

For me, this Congress indicated that such policies are beginning to bear fruit. Some years ago, when I attended a Congress of the research branch of the EAPC in Berlin, we as researchers argued most of the time that more research was needed to improve our knowledge of the needs of people in palliative care. Three years later, I find that such knowledge is expanding worldwide. The plenary lectures and sessions of free communication were full of new research results. The daily poster sessions indicated that much new work has been done in the past years. These were on the subjects of symptom control, evaluation of several new initiatives to improve palliative care, methodology in research, euthanasia and physician-assisted suicide, and palliative care in non-cancer patients (for neurological diseases and dementia).

The excellent set-up of the Congress programme left enough time for building or maintaining networking relationships during the breaks, made possible by the relatively small scale (1500 attendees) of the meeting. Another highlight of the Congress was the effort made to cover non-clinical subjects. Bereavement, psycho-oncology, and ethics were themes that received much attention in the sessions. As Dr Tony O'Brien put it: 'Palliative care gives relief from pain and other symptoms, but it should also offer a support system to help patients live as active a life as possible. Very often this means listening to our patients, who can often teach us more than anyone else.'

To give the whole meeting a festive touch, the closing ceremony took place in the presence of Her Majesty Queen Béatrix. This was a royal ending to an excellent conference, with many new 'take-home messages' to ponder on. There is still much to do in palliative care!

Marjoke J Hoekstra

For more information about the Congress view the EAPC website at ***www.eapcnet.org***

flora medica theophrastus bombastus

From the journals, April 2003

***N Engl J Med* Vol 348**
1322 Acute infection is a common precipitant of cardiac events and stroke in the elderly, so influenza vaccine should reduce these — and it does.
1333 The first treatment that has been shown to help in established Alzheimer's disease — memantine, which blocks glutamergic MDMA receptors.
1425 Following deep vein thrombosis, patients who stay on low-dose warfarin indefinitely have far fewer recurrences, but still need INR monitoring to keep levels between 1.5 and 2.
1556 A study of US primary care showing a high rate of preventable adverse drug reactions. Serotonin re-uptake inhibitors topped the chart, followed by beta-blockers, ACE inhibitors and NSAIDs.
1625 A prospective study of 900 000 Americans shows that fatter people have increased mortality from many cancers.

***Lancet* Vol 361**
1148 Should visit length be used as a quality indicator in primary care? A view from the USA — very sensible, despite the fact that average visits there are about twice as long.
1159 A study which showed that combined oral contraception probably increases breast cancer risk significantly.
1168 The first new diagnostic test for tuberculosis for one hundred years: ELLSPOT, which looks for primed T-cells.
1205 An illustrated guide to body piercing. Gross!
1247 Laparoscopic adhesiolysis has become a standard procedure for symptomatic abdominal adhesions, but it makes no difference whether the surgeon does anything after putting the scope in — as with knee arthroscopy.
1312 There is plenty in all the journals about severe acute respiratory syndrome (SARS); this editorial sums up current management usefully.
1359 A useful review of benign prostatic hyperplasia, pointing out that it is by no means the only cause of lower urinary tract symptoms in men of a certain age.
1405 Two papers about the benefits of mammography, using mainly historical controls. But for a succinct account of the benefits and costs of breast screening, it's best to go to *N Engl J Med* page 1672.
1452 The gunk that blocks catheters is a biofilm of *Proteus mirabilis,* and it may be preventable by filling the balloon with triclosan solution. It works in mice.
1459 Travellers who return home ill are likely to be worried, so it's worth having access to this excellent guide, which doesn't even mention SARS.

***JAMA* Vol 289**
1652 More preventable drug reactions in the Canadian elderly: co-trimoxazole plus glibenclamide causing hypoglycaemia, digoxin and clarithromycin causing digitalis toxicity, and spironolactone plus ACE inhibitors causing hyperkalaemia.
1785 One of several papers about obesity in this issue of *JAMA*, showing a correlation between television watching and obesity in women.
1805 Obesity causes social and psychological problems in adolescents (see page 1813), but combining a behavioural programme with sibutramine can help.
1957 A negative trial of hip protectors in Amsterdam nursing homes.
2038 Lifestyle modification may be the ideal initial management of high blood pressure, but at what cost? Eighteen visits in six months, in this study.

Other Journals
Women who give up HRT lose bone rapidly, so should we give them bisphosphonates right away? ***Arch Intern Med* 163: 789** shows that alendronate works very well. An eminent professor of general practice recently laughed at my suggestion that most diabetic patients should be on six or more drugs. Look up ***Ann Intern Med* 138: 593** — effective blood pressure lowering is essential, and that alone may need four.

Helicobacter pylori has its own journal — no mean achievement for a spirochaete — and ***Gut*** tends to be pretty full of it too. **Volume 52: 637** shows that eliminating *Helicobacter* causes a surge in grehlin, the appetite-stimulating stomach hormone. ***Arch Dis Child*** is always worth a browse — see **88: 324** for a study of vulvovaginitis in prepubertal girls, often caused by streptococci. But if you find the mainstream journals a bit stuffy, you can always open a window on ***Indoor Air* 13: 53** and learn about *Ventilation and health symptoms in schools: an analysis of existing information.*

Plant of the Month: *Rosa* 'Grüß an Aachen' Climbing
Few roses can match this one for subtle transformations between cream and pink, for scent, and for continuous flowering. But the climbing form is no longer available commercially. If you find one, let me know.

What is man?

WE do not come into this world with any labels attached. Man is to himself a mysterious creation. This question is the old question about the nature of man, in which, as men, we all have an understandable interest. The psalmist asks God,

> *What is man, that you are mindful of him,*
> *Yet you have made him a little less than a God?* (Psalms 8; 4-6.)

The psalmist ponders the question of man's nature. He finds him awkwardly placed between insignificance and near divinity. The same is true today. One minute, in the consultation, it seems as if a near-divine power of sympathy and understanding is flowing through me, yet the next minute in the coffee room I can get thoroughly upset over some insignificant or imagined slight.

How we understand man has a big effect on what we see of him, and therefore how we treat him. Some people hold an unquestioned model of man, the model that they learnt as they grew up. Such people can be thrown as they realise that other people hold a quite different model. This realisation can be brought about by studying sociology or psychology, by meeting other cultures,[1] or simply by the infinite variety of general practice. It can be a reassurance to realise that only certain models of man are in general use in our culture. The following three models might be held, to some degree, to classify most of the models available to us.

1. *Rational man* — man as an individual man,
2. *Social man* — man as primarily a member of a group, and
3. *Religious man* — man seen primarily in relation to a creator.

Each model finds its adherents in contemporary European culture.

Rational man

This is probably the dominant model now, especially in academic circles. It can be described as follows. Man is seen as a rational individual. He chooses his actions by deciding what is best for him from his individual point of view. Society is seen simply as an aggregation of pre-existing individuals. This is how Hobbes saw society.[2]

This picture of rational self-interest as a dominant force has built up slowly. Where La Rochefoucauld[3] emphasised that apparent altruism was often hidden self-interest (rather than the opposite of self-interest), Hume[4] saw self-interest as one among many motivations. That flower of the Scottish enlightenment, Adam Smith, did not see man as purely rational, but appealed to rational self-interest as a protection against man's pride.[5] Only when we reach Bentham[6] or Nietzsche do we find philosophers who held that altruism could not exist, and all was self-interest. This emergence is well described by MacIntyre's *A short history of ethics*.[7] This model of rational man (that is, a purely self-interested man) is that of most contemporary economics and some political science. It has proved an excellent model where there is a possibility of quantifying data, and it has shed light on many aspects of human behaviour. However, it is difficult to use it to account for the possibility of man's co-operation with man because each man is seen as making his own self-interested decision. Altruism is seen by some as a disconfirming case for the 'rational man' model. A true believer in rational man theory, if he accepts that altruistic motives occur, albeit rarely, has to admit of the existence of a world beyond the perceptions of his previous 'view-of-the-world'. Indeed, this is explicitly the journey taken by Monroe[8] and Batson (a social psychologist)[9] in their rather different books on altruism. Driven to extremes, the 'rational man' view leads to an extremely poor picture of man, whose ultimate logic is depicted by WH Auden in *The Shield of Achilles*.[10]

> *That girls are raped,*
> *That two boys knife a third,*
> *Were axioms to him, who'd never heard*
> *Of any world where promises are kept,*
> *Or one could weep because another wept.*

Auden is pointing out that if there is only self-interest, then it will be a bleak world indeed in which we live.

The difficulties this model presents have been well described by Hardin's 'tragedy of the commons' where the cows overgraze land held in common.[11] A whole volume of essays bringing together current criticism of this model, from contemporary economics, politics, and psychology, has been published.[12] There have been two contemporary developments of this picture. According to Ogden,[13] psychological theory has come from seeing man as a passive responder to stimuli to seeing him as an active appraiser of risk, first in the environment, and increasingly within his own self. Giddens[14] has described post-modern man as defining himself by the choices he makes. By this he means, for example, that I choose my food in order to define and declare who I am, rather than eating what is normal or thought suitable for my state in life.

The social model of man

In this model, a person is defined by his position in society. He is, as it were, constituted by the rights, duties and norms of his position. It is a familiar model to anyone who attended a public school or

essay

This article is based a project that was supervised by Dr Jane Ogden. The project was completed as part of a MSc degree in general practice at Guy's King's and Thomas's Medical School, London.

other comparable institution. The essential facts about a boy are stated by his position in the school hierarchy, not by his personal choices. A boy is defined by being, let us say, a fifth-year boy in a certain house with certain privileges and duties. If one knows this, then nothing else is worth knowing about him. His thoughts and actions, indeed where he is at any moment of the day can be confidently predicted just from this knowledge. In a similar way Marxists believed that a man's essential being was determined by his economic position in society, his social class. This was the structure. Anything else, his religion, his opinions, was called the super-structure and could be determined from it. An analogy can be made with language. Language does not exist in the absence of human beings, yet it precedes the existence of the individual. Language moulds and limits the ways individuals can think. The same may be said of the rules of society. (This is one of the insights of the structuralists[15]). Certain goods, especially money, have no 'objective' existence, but are essentially 'social' goods.[16] Within this model altruism is not a problem. Both altruism and 'rational self-interest' are seen as alternative social norms. So this model can explain altruism and much human behaviour. Yet it can be taken too far and lead to the dreadful totalitarian excesses of Nazism and communism, both Russian and Chinese. The engineered famines of Stalin in the Ukraine in the 1930s and Mao in China in 1958 spring to mind. This last famine, engineered by man, caused many more deaths than World War II.[17]

Religious man

Religious man is defined primarily by his relation to a creator. Belief in a creator is common to most but not all cultures. If a creator exists then one's relation to him is of great importance. Even if we think that there is only a small probability that he exists, the stakes are so high that we may be wiser to bet that he does exist. This insight is known as 'Pascal's wager' after Pascal, the founder of modern probability theory, who first set it out.[18] Religion provides many people with a meaning for their life, and indeed for suffering and death. However, exclusive attention to this relationship with the creator also leads to an impoverished picture of man. In the following passage Thomas Merton, who as a Trappist monk was vowed to a lifetime of poverty and silence, opposes an exclusively 'vertical' relationship with God:

> *'For it is the survival of religion as an abstract formality without a humanist matrix, religion apart from man … religion without any human epiphany in art, in work, in social forms: this is what is killing religion in our midst today, and not atheists.'*[19]

It was men who believed that only the vertical relationship with God was important who were responsible for the Inquisition and for mankind's innumerable wars of religion. From this perspective, if only man's relationship with God is important, then one can justify 'killing a man in order to save his soul'.

In a previous article I contrasted a polyphonic discourse (one where several different models are heard with mutual respect) to a monologising discourse, which comes from the belief that one model holds the full and exclusive truth.[20] This, I believe, is our situation with these models of man. Each can tell us something about him, but if any one is taken exclusively, as a monologising discourse, it leads to danger. Initially it leads to blindness about things outside the model. For example, in the models above, rational man cannot perceive altruism, social man devalues personal beliefs, and an exclusively religious perspective fails to perceive the value of social life. Eventually, a monologising discourse can lead to tyranny. First, it can lead to a state organised only for people who are willing to fit in with a certain understanding of man. Then it can sometimes lead to a state that sponsors torturers to stretch or chop people until they fit into, or accept the validity of, their scheme. In the models above, the rational man model might lead to unbridled liberal economics, the social model might lead to the totalitarian state, and the exclusively religious model to religious persecution. Different models of man also lead to different therapeutic possibilities, as beautifully explained by the psychiatrist and philosopher Patrick Bracken in the case of post-traumatic stress disorder (PTSD).[21] Bracken claims to show that the basis of the current treatment of PTSD by cognitive psychology is the Western understanding of an individual rational man who actively constructs his personal meaning from his own life. Trauma is seen as disrupting this life task, and cognitive therapy makes it possible again. Bracken found this approach of little use when he worked in Uganda with African survivors of the terrors of Amin's regime. This was because, for them, their life's meaning was given by unquestioned beliefs, and by their place in society. Hence, for them, the urgent task was to restore broken social bonds. It was this that restored meaning, not intra-psychic work to restore cognitive schema.

There is one final distinction to make. To say each insight into the nature of man is partial is not to commit oneself to the philosophical position that there is no objective truth about the nature of man. It is compatible with the position that there is an objective truth, which may be partially grasped in a number of different ways.

Gervase Vernon

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Regions of the Great Heresy — Bruno Schulz, a biographical portrait
Jerzy Ficowski
Norton, 2003
HB, 256pp, £19.95, 0 39305147 1

BRUNO Schulz, the Polish-Jewish writer and artist, was born in 1892 in the Galician town of Drohobycz, then a part of the Austro-Hungarian Empire. His father ran a haberdashery shop; the family was comfortably off, secular and fairly well assimilated. In 1915, Schulz's father Jacob died, and Drohobycz's marketplace, including his father's shop, was flattened by the Russian army. This was the great divide in Schulz's life. Unlike Kafka, to whom he bears some resemblance, he doted on his father. All his subsequent writings were to become a mythological consecration of his father's cabalistic speculations in the backshop. Double-entry book-keeping has rarely been described with such entrancement: 'The Book lay in all its glory on my father's desk, and he, quietly engrossed in it, patiently rubbed with a wet fingertip the top of decals, until the blank page grew opaque and ghostly with a delightful foreboding and, suddenly, flaking off in bits of tissue, disclosed a peacock-eyed fragment.'

War ended in 1918, and Drohobycz became Polish (it is now in western Ukraine). Schulz went on to earn his living as an arts and crafts teacher, and wrote and painted on the side. He was a shy and sexually frustrated man, to judge from his weirdly compelling drawings, which show dwarfish creatures fawning on elegantly bored young girls. It was only through the intervention of friends in the 1930s that his stories were published at all, in the volumes *Cinnamon Shops* and *Sanatorium under the Sign of the Hourglass*. The literary sensation started a frantic correspondence with established figures in Polish letters such as Witkiewicz (Witkacy) and Gombrowicz (a selection was published in English in 1988). He fell out with the latter when he pointed out that for the 'doctor's wife from Wilcza Street' (an invented philistine) his stories were 'just pretending'.

Schulz clearly was a late Romantic: in a letter of 1936, he avowed that wanting to 'mature' into childhood was his artistic aim. He sets out to make the modest town of Drohobycz into something like a modern Babylon: his stories are dominated by preternatural seasons, the peculiar splendours of provincial life, and a parental home where every door might be the secret passage to the archives of the cosmos. Almost every story has the same small cast, in particular the enigmatic, impractical figure of Father dreaming of demi-urges among his bales of cotton, and his arch-enemy, the housemaid Adela, who is efficiency with a broom. In the background is Mother, the guarantor of normality, presiding over what she thinks is a family (and getting small thanks for her sanity); though if she'd merely looked over her writing son's shoulder she would have seen metaphors going on the rampage, and sucking up all the mundane air. There is a distinctly greedy quality to Schulz's writing.

Sixty years is a long time to be in thrall to anyone's work: Jerzy Ficowski, a noted Polish poet and critic himself, has done more than anyone to bring Schulz's work to light since first reading him in 1942. That same year Schulz was casually gunned down on the street by a Gestapo officer who bore a grudge against his protector, a Viennese Nazi who had commissioned him to paint fairy-tale 'frescos' in various parts of town. His dismal death, on a day on which 100 Jews in Drohobycz were summarily executed in a 'wild action', was nothing at all like the splendidly orchestrated end of the world announced in his novella *The Comet* when 'the curtains blew out far into the night and the rows of rooms stood in an all-embracing, incessant draught, which shot through them in violent, relentless alarm'. Hidden behind whitewash and plaster, Schulz's polychromes were accidentally stumbled upon just two years ago. In a troubling coda to his book, Ficowski relates that shortly after their discovery the paintings were pried from their supports and secretly conveyed to the Yad Vashem museum in Israel, which claimed it was the proper place to preserve them — surely a bizarre imposition of identity politics on a man who claimed Drohobycz was his 'one and only town on earth'.

Schulz has remained a kind of open secret, a writer's writer, even: he plays a role in major novels by Danilo Kis, David Grossman and Philip Roth. In Cynthia Ozick's *The Messiah of Stockholm*, the long-lost manuscript of a novel called *The Messiah*, which Schulz is thought to have been working on in his last years, turns up, like the Messiah himself, when least expected. Ficowski's book (in Theodosia Robertson's fine translation) will probably be of most interest to readers already familiar with the teeming nursery of Schulz's imagination. Those who need to be dazzled by his unique stylistic meld of wisdom literature, Linnean Latin and biblical allusions should turn to the two volumes of short stories, or to one of the novels in which Schulz turns up as a kind of heresiarch of dreams to enjoy, like his father in his own writings, a partial existence 'under the sign of the hourglass' — a life in literature's mythic time, which settles in puddles beside the unremitting one-way traffic of the real.

Iain Bamforth

Further reading

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Three Hundred Years of Peter

In May 1703 the city of St Petersburg started its glorious history, founded by the Russian Tsar Peter I as a new capital of Russia. For a while the country had two main cities. St Petersburg has been for two centuries modern, fashionable, stylish, new, Western — the head of the Russian Empire. Moscow was an old-fashioned keeper of the spirit, the mysterious Russian soul, the heart of Russia. Today we can say Moscow is the formal capital — the centre of administration, the seat for the government, while the city of St Petersburg has developed into a cultural capital of the new Russia.

Nowadays St Petersburg looks forward — in the development of science and of art, and of something that belongs to both fields — medicine. The development of medicine rests with the St Petersburg Medical Academy for Postgraduate Studies (MAPS). MAPS is looking brand-new, like many buildings in the city, and inside we are improving the quality of teaching medicine to postgraduate doctors.

If you happen to be in St Petersburg this summer, marvel at the beautiful palaces, big broad squares, straight streets, numerous blue rivers and canals, and our bridges with exquisite cast-iron ballustrades. St Petersburg is cleaned and freshly painted. The renovations of architectural masterpieces have not touched the basic interiors, but they have added to the exterior, the outer look.

We have renovated medicine too. Reforms are changing the core of medicine, and changing the mentality of doctors, so that as the result, the human being of the 21st century will finally get something to please his whole being — the medical approach that will bring together the body, the mind and the spirit. Today's medicine is not just diagnosis and treatment as it used to be. It is also health promotion and disease prevention. 'Mens sana in corpore sano', ('The healthy mind in the healthy body') — the Romans used to say. Three centuries have not passed in vain. They have allowed our 'beautiful minds' to bloom in the beautiful environment of the great city of St Petersburg.

So today we celebrate the three hundredth anniversary of a comparatively young city — our coming of age. And medicine, and the medical world in general, celebrates the victory over dogmas, rigidity, and conservatism. It is not by chance that St Petersburg has been chosen to take the responsibility for developing the new field of Russian medicine: family practice.

Olga Kuznetzova

john a j macleod

Birds or humans?

Is it really public demand or is it just the whims of media editors that has led to our Hebridean islands being almost drowned in a sea of news reporting? Bird migration had hardly begun and rooms were still being made ready for Easter tourists when the swarm arrived and soon filled the beds and took up all the cars available for hire throughout Uist. This was not to follow up the story of the lack of a renal dialysis machine that had the Health Board paying out some £5000 a week to transport a patient to and from a mainland centre of excellence, but were all in the hunt for hedgehogs that were due to emerge from their sites of hibernation, often in the middle of peat stacks and close to houses.

For years, Uist has been plagued by flocks of Greylag Geese who now breed locally in profusion. When I was young, the Greylag arrived in majestic 'V' formations from their summer breeding in the Arctic. At that time, the local arable crop was short-eared oats and barley, cut by scythe or mower and then bundled into sheaves that were 'stooked' on end to dry before being carted home and built into large stacks beside the byre.

Then, the Royal Society for the Protection of Birds declared an area in South Uist as a protected reserve for Greylag to stay all summer, nest and raise local broods. This cult has spread through the Uist island chain and for some years the infestation has been a menace from early in the year. From July onwards, crops are eaten as they stand, and the loss, to the struggling crofter, is at least an average of 10%, with more isolated fields losing 50%. For ages, various committees have met and discussed the problem. A wide variety of scaring mechanisms have been tried but they just move the birds on to a neighbour's ground. Out-of-season shooting licences can be arranged but only to cull a limited number and the granting of such a licence is sometimes dependent on a count of 'droppings per square metre'. There has been absolute refusal by officialdom to permit the simple and locally advocated solution, which is to prick the eggs in the nests. By doing this, the goose will continue to sit but the eggs will not hatch and so, for each nest, there will be six less Greylag to nibble the sparse winter grass.

This refusal to forcefully deal with a problem that, indirectly, affects humans contrasts dramatically with the reaction when it was shown that wild mink and hedgehogs were chewing up the eggs and young of ground-nesting birds. Uist, with its varied topography and virtually no trees, is world famous for its wading birds, which all nest on the ground. £1 million was assigned over three years to set up a trapping scheme, to control the spread of mink and then several thousands became available to cull hedgehogs. No public fuss about mink being despatched to their 'other world' but near hysteria at the concept of humane killing of the 'pretty' hedgehogs. Argument continues in relation to culling or translocating the hedgehogs and the media from across the world have been here to follow the story. Who would have thought that there was a war in Iraq or that elections to the Scottish Parliament and local Councils were imminent? A few years ago, in a debate on the environment, one of our local councillors stated 'people are coming here to view the birds and sea mammals but in twenty years, they will be coming to view the few humans who are still resident'. Extreme perhaps, but he may well be right.

This hedgehog issue (£5 per live animal from one organisation) has truly captured world interest, with even the *New York Times* (4 April 2003) devoting one-third of a page to a detailed story on local reactions. However, the impending lack of GP cover for an isolated area on Lewis has only had minimal brief and short-term publicity.

BJGP *editorial subcommittee meeting, Wizard Pool, Loch Skiport, South Uist, May 2002. Photograph by James Willis.*

A view from inside the SARS epidemic

The early days

Monday the 10 March 2003 started in a manner not dissimilar to other Mondays. There were some problems from the weekend to be cleared up; a patient recently returned from Mainland China had died of pneumonia, and a number of healthcare workers from another medical ward had reported sick with a 'flu-like illness. We had been aware for several weeks of 'atypical pneumonia' in patients who had recently travelled to Guangdong Province just to the north of Hong Kong, but at this stage the disease was a curiosity notable mainly for its apparently high mortality and obscure aetiology. We did not know at that stage that the disease was unusually contagious.

I chose to pursue the cluster of staff 'flu-like illness in ward 8A. We discovered that more than ten staff from the ward had reported sick over the weekend with fever, myalgia and dizziness and there was also an impression that several of the patients had spiked high fevers. Feeling a sense of unease that the situation seemed quite unusual, I decided to head straight to the office of the Professor of Medicine, who was standing outside his office being briefed by his nurse manager. No doubt he knew it was trouble when I approached — to work in infection control is always to be the bearer of bad news.

By noon of that day our outbreak management group had started work, and it was clear very soon that our problem was escalating rapidly. We arranged to recall sick staff to perform nasopharyngeal aspirates for rapid viral diagnosis, and to our surprise 78 staff members presented for sampling. We were also aware by then at least five patients had a similar illness, and infection control measures were introduced in the ward, including closing the ward to new admissions.

I started work the following morning with the feeling that things could only get better, but I was quite wrong in this regard. Around lunchtime I was called by an irate surgeon who said that three doctors on his team were sick, and one of these had been admitted with pneumonia. His team members had recently visited the outbreak ward to see a patient. This was the first report of pneumonia in staff, and a sign that our situation was becoming very grave indeed.

In the early evening of Tuesday 11 March, it was decided to screen sick staff in a hastily arranged evening clinic set up in a conference room. Still ignorant of the likely cause, we self-medicated from large jars of levofloxacin and packets of tamiflu supplied by the pharmacy, put on our masks, gowns and gloves, and headed into battle. I was surprised that the clinic attracted around 50 staff, as it was arranged at only a few hours notice. The clinic proceeded in an eerie calm as the physicians examined and arranged chest X-rays and blood tests for the sick, most of whom were doctors, nurses, and medical students from their own department. After several hours, everyone had been processed and a briefing was held in another room. One group had mild symptoms and negative investigations and were to be sent home with advice to return if they became sicker (most did). The other group had severe symptoms or abnormal chest X-rays and were led off in single file to an observation ward which had been commandeered earlier in the evening from a reluctant professor of A&E medicine. During the evening we had also received disturbing news; there was an outbreak of atypical pneumonia in Hanoi, Vietnam, related to a Chinese-American patient who had recently arrived from Hong Kong. The secondary attack rates in exposed healthcare staff in Hanoi were more than 56%, and the disease had a significant mortality rate. There seemed little doubt that it was the same disease — we were not alone.

Crisis

By mid-week our situation had progressed to a fully-fledged crisis. The number of persons affected rose rapidly and we saw also more staff, more patients, ex-patients, visitors of patients, and family contacts of all these presenting with the disease. By mid-April, 124 staff, 25 patients, and 31 ward visitors were documented as having acquired the disease. Several GPs who had seen the patients, their visitors, or their contacts, also developed the disease.

Towards the end of the first week the probable source case was identified; a 26-year-old man who had pneumonia that resolved spontaneously, but who had been given nebuliser therapy. This may have led to more extensive dissemination of the causal agent in the ward. The WHO had officially announced the Severe Acute Respiratory Syndrome and put out an unprecedented world health alert. Despite that, we felt rather isolated. Other Hong Kong hospitals viewed it as a Prince of Wales Hospital problem, the Minister for Health was adamant that SARS had not spread to the Hong Kong community, and the rest of the world was much more interested in a war just started in Iraq.

Nor was there much more optimism on the clinical front; the typical clinical course was of a slowly progressive pneumonia, with 20% or more patients requiring care in the intensive care unit. There was also a real concern that the ICU capacity would be swamped. We had a moment of relief when our virology laboratory isolated a paramyxovirus from many patients but this was short-lived — another laboratory isolated a coronavirus several days later, and this appears to be the causal agent of SARS.

At about the same time, issues of managing staff became prominent. Many new staff were required to operate the SARS wards, and many of these were from other departments of the hospital. They were mainly volunteers. The response of the staff was on the whole magnificent, but levels of anxiety were high. Most were willing to take the risks associated with fulfilling their professional obligations, but were naturally unwilling to expose their families to these risks. There thus followed a dramatic disruption in the domestic lives of many hospital staff. Some moved to hotels,

SARS by numbers...

[From: Donnelly CA, *et al*. Epidemiological determinants of spread of causal agent of severe acute respiratory syndrome in Hong Kong. *Lancet* 2003 (May 7). URL: http://www.thelancet.com/journal/vol361/iss9368/full/llan.361.9368.early_online_publication.25595.1]

- Number of SARS cases in Hong Kong up to 28 April 2003 = **1425**
- Average incubation period = **6.4 days**
- Average time from onset of symptoms to admission = **3 to 5 days** (longer intervals earlier in epidemic)
- Case fatality rate (in patients admitted)
  > 60 years — 43.3% (95% CI = 35.2% to 52.4%)
  < 60 years — 13.2% (95% CI = 9.8% to 16.8%)

some to the hospital, some slept in their offices, some asked their families to live with relatives, and some found ways to isolate themselves at home. For those continuing to go home the hospital gave advice on measures (such as wearing a surgical mask, avoiding close contact) to minimise spread at home. I spent only five nights away from home after my exposures in the early days of the outbreak, but many of my frontline colleagues have now not lived with their families for two months.

Stabilisation of the outbreak

As the weeks progressed, our efforts to reduce infection rates began to be successful. For some time, we continued to see staff acquiring the disease in SARS areas but careful implementation of infection control protocols and enhanced training led to reducing rates. All those involved in disease control were under enormous pressure to bring the outbreak to an end, which was all the more difficult given the limited disease information available. Given the lack of hard data, there were heated debates on appropriate infection control measures, particularly in relation to the use of masks and gowns.

There were also now outbreaks in other countries such as Singapore and Canada, so we were now part of a very international problem.

By this time, SARS was perceived as a problem in our community. Schools were closed, restaurants, trains and buses were unusually quiet, and mask wearing became the norm on the streets. Many flights in and out of Hong Kong were cancelled, and some countries introduced quarantine measures for persons arriving from Hong Kong. The tourist industry has been devastated. This has all occurred at a time when the Hong Kong economy is struggling to recover from a deep recession, and the economic impact of the outbreak on the local economy is likely to be significant. The SARS outbreak now affects the lifestyle of all seven million people who live in Hong Kong.

The future

At the time of writing (6 May), there is finally some room for cautious optimism that the disease is being controlled in Hong Kong, if not in mainland China. The number of new Hong Kong cases is declining day by day and fewer healthcare staff are affected.

There is, however, a feeling in the medical community here that something has changed, and possibly forever. Never again will doctors be so blasé about their contacts with patients, and in particular those with fever. We will continue to cohort febrile hospital patients in our 'infectious triage' areas both in the emergency department and the wards. Doctors in the community will continue to wear masks and gloves. Whether the SARS outbreak is controlled or continues, it seems likely to leave a lasting legacy in the way doctors interact with their patients.

Donald J Lyon

roger neighbour - behind the lines

On the tango

As a limpet on a camel, so are you likely to find me on the dance floor. It's the body-work I can't get the hang of; it just seems so much algebra for the limbs. When the music starts I immediately make an inhibition of myself, developing a paralysis so complete that bystanders look around to see who fired the curare dart.

I suppose I could always learn. Trouble is, my learning style's against me. By nature, I'm one of those cerebral types who like to grasp the concepts and master the theory before attempting a new skill. It's pathetic: my shelf of golf instruction manuals is as long as my handicap. But you'll perhaps understand why it was with mixed curiosity and trepidation that I opened a recent *BMJ*[1] and found it was a special themed edition devoted to — dancing.

Of course, being the *BMJ*, they dressed things up a bit. Not for them the diagrammed sequences of black and white footprints, or coy references to 'the lady and the gentleman'. Here, the dancing partners were designated 'doctors' and 'managers', and the key teaching point was this — it takes two to tango. But why a special edition? Well apparently, whereas doctors and managers as individuals and in the separate privacies of their own professional worlds can be lovely little movers, they've recently started going out together, and things aren't looking good in the dancing department. Initial sorties by the doctor–manager combo onto the sprung floor of the Healthcare Delivery Ballroom have been characterised by unseemly fumbling, clumsy footwork, and some very bruised toes.

The problem, it seems, is that doctors think managers all have two left feet, and managers think doctors all have two right ones. Or, as the *BMJ* puts it, there is 'mutual distrust, personal abuse and blame', the protagonists having 'differing world views, steeped in historical rivalries that resurface at each encounter'. This should surprise nobody; managers cannot afford to become preoccupied with the needs of an individual patient irrespective of the consequences for others, while doctors can't put pre-ordained policy above the interests of the patient in front of them. We are all familiar with the attrition in the stand-off between medical and management value systems — the silly targets, the runaway drug budgets, the phoney waiting list statistics, the redefinition of ideals such as quality, effectiveness, and care.

The solution, eloquently elaborated by the *BMJ*'s team of dance tutors, is also familiar. Doctors and managers need to quit behaving like prima ballerinas and start hoofing it as a proper twosome. It would be easy to cringe at the clichéd banalities in which this injunction is couched — 'constructive dialogue', 'interdisciplinary education', 'working towards the alignment of mission and strategy'. Easy, but wrong; for (we are told) 'only a well functioning relationship can deliver real service improvements.'

Uh-oh. Did you clock the 'only'? An 'only' like that usually means someone is trying to slip a fallacy past you disguised as a truism. But surely no-one could quibble with a call for doctors and managers to stop playing games and start relating like adults? Yet a fallacy there is.

Playing games? Relating like adults? Where have you heard this before? Of course — Eric (*Games People Play*) Berne's *Transactional Analysis*, with its devastatingly insightful depiction of the human psyche as a Parent-Adult-Child triad. In a refinement of Berne's model, Stephen Karpman described a 'drama triangle',[2] where the players of psychological games rotate around the roles of Victim, Persecutor and Rescuer, scoring points off each other as they go. (Doctors and managers will smile a guilty smile of recognition.) A corollary of Karpman's analysis is that when two parties are in unstable role equilibrium, *cherchez la troisième*. And who is the unseen third dancer, neither the deliverer of healthcare nor its organiser? Why, the policy maker! The politician. Add 'politician' to the dyad of doctor and manager, and (although there may be disagreement over how the roles are to be allocated between them) Karpman's triangle takes on a terrifyingly accurate verisimilitude.

And where are the politicians, the draughtsmen of the big picture, in the *BMJ* analysis? Nowhere; not a single mention; air-brushed out. They are the Teflon tribe, to whom no responsibility may be seen to stick. They have control without involvement, power without experience. Their accountability to the electorate is, compared with doctors' vulnerability to complaint and that of managers to performance review, occasional and perfunctory.

So let us call for our politicians too to stop playing games with the NHS and get involved like responsible adults, on an equal footing with the other two parties. Come and join the dance. It would be an unfamiliar sight — doctors, managers and politicians, arms linked and high-kicking. But this much I know about dancing: it takes three to tango.

References

1. *BMJ* **326**, 22 March 2003. Subsequent quotations are from editorials and articles in this issue.
2. Karpman SB. Fairy tales and script drama analysis. *Transact Anal Bull* 1968; **VII(26):** 39-43.

Think William Harvey; what comes into your mind? For me it is a medieval man's right forearm with a tourniquet and a network of veins and valves prominently displayed. Think Barbara Starfield and what comes to mind? Blank?

Shame on you. Barbara Starfield is to primary care what William Harvey was to circulation. Before him it was a woolly exercise involving humours and a bit of ebb and flow. After him it was all measuring and monitoring and pumping.

Before Barbara, primary care was a woolly exercise too, all give-and-take with, thankfully, some humour.

She has methodically and systematically taken primary care apart and shown us all how it works. She has given us criteria to measure it and can tell you what works and what does not. She talks of the Four Great Pillars of primary care: Access, Generality, Longitudinal Care, and Co-ordination.

At the Spring Symposium she demonstrated the confidence she has given primary care by daring to look the great Hospital Beast in the eye and demanding, 'and what exactly do you do?'

I don't think her diagrams are as good as William Harvey's and she is shorter than I imagined, but I was there.

James Cave

ON a glorious spring weekend I had some difficulty in dragging myself down to the Wills building in Bristol, palatial cenotaph of long-dead tobacco barons. But after 20 years' membership without attending a conference once, the journey, as the Michelin Guide would put it, was worth the detour.

Dress code varied from academic gowns (briefly disclosed behind closed doors after earnest group discussion) via formal lounge suits to motorcycle leathers. One or two members present wore those trousers you unzip the legs from, as if about to burst into a surf guitar break. No registrars came, perhaps reluctant to be so sartorially outgunned. Some members loathe arcane ritual and dressing up, but the mace (topically resembling a chrome-plated anti-tank missile) was whipped out among consenting adults and rather impressed us all.

Most memorable moments: David Haslam reflected on the East Anglian origins of his career; George Alberti told us just what is being done about our collapsing A&E services, Dame Lesley Southgate (though a member of the anti-dressing-up faction) described what it was like to be transformed into a Dame, and guided us into some imagery of what Presidents wear underneath their robes.

Small groups looked at learning pathways with IT, teenage health, and the College's values, and they evaluated NHS Direct and Walk-in Centres, academic practice, diseases and non-diseases, and teenagers from a local school role-played seeing the GP, putting us firmly in our places.

The BBC broadcast 'Any Questions' during the conference, with Liam Fox, Frank Dobson, Anne Leslie and Jenny Tonge. The best question was 'Would the NHS cope with an epidemic of SARS?' The politicos opined earnestly that, yes, the HMS *World's Envy* would as usual cope splendidly … this was rash in front of a GP audience, as the questioner then pointed out pithily that the NHS can't cope already, never mind SARS (cue applause).

We were finally shown a travelogue commending the fleshpots of Bournemouth for next year's Spring meeting; certainly worth a detour.

Stefan Cembrowicz

WELL, the weather was suitably spring-like for my first attendance at an RCGP Spring Meeting. It loaned an air of optimism to the weekend that was a welcome contrast to the rather gloomy oak panelled rooms of the venue.

Curious to see what sort of GP turns up to these occasions, I was not disappointed. You can see instantly why both the BMA and the RCGP have a devil of a job trying to round up a collective voice. The expression 'herding cats' comes to mind.

There were cats in three-piece suits, cats in jeans, cats in Armani, cats with pigtails and earrings, cats wearing Manolo Blahnik shoes, cats in trainers, leopards in frocks, civets with wigs, lions, cougars, cheetahs and a few others I hadn't even come across before. Trying to persuade the cats in my group to identify a shared view for the future of the College proved a challenge.

So did attempting to consider the implications of the changing workforce. One can't help but think Mrs Thatcher is still to blame. She somehow epitomised the idea that you should forge your own path. To hell with the collective good — that was all wishy-washy socialist nonsense. This doesn't sit well with the vocational aspiration of the GPs of yesterday's generation. But here we were, really trying hard to identify some common ground. It became evident that there was less of a collective vision and rather more of the crash barriers either side, of guidelines, protocols, GMC 'What You Must Do Now' booklets. Not helped by the RCGP's own publication ('How to be a Good GP') which makes me feel about as adequate a GP as the 1950s *Good Housekeeping Guide* ('How to be a Good Wife') makes me realise that I am a wholly adequate wife. Perhaps I should give up now.

Actually, my only real frustration of the evening was the parallel sessions. I always waste at least 90 seconds wondering if the others are more interesting/useful or whatever.

Amidst all this, there were many enthusiastic, entertaining, innovative, and bright folk at that conference who clearly still harbour that unfashionable belief that the whole really is greater than the sum of the parts. Perhaps the College should aim to be the conductor of an orchestral chorus of cats, whose members are allowed to swap position and/or instrument as time, the mood or the need arises.

I am off to learn to caterwaul in tune.

Kirsty Alexander

IT was a great privilege to attend the Spring Meeting of the RCGP in Bristol. I have been involved with the Wessex faculty of the RCGP since starting my

vocational training in Winchester and find the contact very stimulating and rewarding. Sharing ideas and discussions with colleagues who have far greater expertise than I do has already broadened my approach to general practice, and increased my awareness of issues around and beyond those of patient and consultation.

Thus, to find myself as one of very few registrars at the Spring Meeting was something of a disappointment. I chose to attend the College session and my small discussion group consisted of almost the entire spectrum of general practitioners — from registrar to retired. Enthusiasm for College activity was mixed. On Sunday morning I was also interested to hear that many of the questions posed to the panel were 'anti-establishment' and it seems that the College is under threat. Call me old-fashioned (and many people have), but does long-standing tradition not count for anything? There is a danger that tradition and establishment are being rubbished in order to keep 'up to date' and attractive to younger members of the profession. However, can we not maintain the history but accept change as well? Change — my favourite word.

I was honoured to participate in the presentation for next year's conference, to be entitled 'A Sea Change', which is to be held in Bournemouth. After my experiences this year, I am extremely keen to encourage the attendance of more registrars and GPs in training. The opportunity to hear from GP gurus and contribute to seminars is important at all stages of learning for general practice. The College is not just about a membership examination, which sadly seems to be the overriding image perceived by young GPs.

The future of general practice is at an interesting hiatus as we await the evaluation and introduction of a New Contract. This can only be an exciting time to be embarking on a career in general practice and perhaps we are privileged to be arriving in the new regimen with little or no experience of the old system and Red Book. The future is bright — the future might even be an Orange Book! Part of our role is to remain enthusiastic and maintain a vision beyond the doubts of senior colleagues. Otherwise, how will general practice be maintained? Barbara Starfield, giving the William Pickles lecture, advocated that British primary care is the envy of many health systems across the world. Registrars are part of the future of that care.

Jo Boughton

neville goodman

Will Barefoot ask Emma?

So, helped by Richard Dawkins' latest book, how are we logical rationalists getting on? How have things changed since we last railed against the forces of unreason? Not well, I'm afraid. The *BMJ* uses its careers section to let anyone with a mission write articles explaining how they were once just orthodox practitioners but now they've seen the light. The Department of Health has decided, because lots of folk want them, to waste £1.3 million on researching alternative therapies. The *Daily Mail* scored for us by reporting that homoeopathy doesn't work, but perhaps the government doesn't read the *Mail*. Or perhaps they do but don't believe it. In which case they have at least one thing in common with me.

Rationalism certainly hasn't affected the Barefoot Doctor. He continues to sully the pages of *OM*, the *Observer*'s glossy supplement. His branded wares can be found in Boots the Chemist. He's written books, which may even sell more than Richard Dawkins. It makes you weep.

'I read with interest', writes Rachel Parkes (*OM*, 27 April), 'your recent piece about the value of the gall bladder in decision-making.' And Rachel wants to know how she can go on making decisions after her cholecystectomy. Quite a poser, eh? Luckily, the Chinese, currently throwing herbs, needles and things to unblock energy channels at the SARS virus, have an answer. As they always do. The relevant 'orb' contains the liver as well as the gall bladder, so the liver can take over its emotional functions when the gall bladder is removed. I wonder how quickly that happens? Laparoscopic cholecystectomy makes the operation almost a day case procedure: will the liver be thinking clearly soon enough?

The *Observer*'s stablemate, *The Guardian*, is onto Barefoot. It now publishes a weekly science tabloid (*Life*), containing a wonderful column entitled 'Bad Science'. The column has been going only a few weeks but already the compiler has asked not to be bombarded with Barefoot's musings. Except that the *The Guardian* doesn't even need to look that far. They have their own 'Ask Emma'. Emma Mitchell ('a natural health therapist') has advice (*Guardian Weekend*, 3 May) for a 50-year old woman who has noticed small lumps under her skin that are increasing in size. Emma reckons the most likely culprit is less efficient fat metabolism brought on by the menopause, or sluggish circulation. Her columns, like Barefoot's, are sprinkled with kidney energy and things that safely boost the immune system.

Incidentally, Barefoot reckons that, instead of Viagra, 'press your fingers into your perineum and massage in circles 81 times.' On that, he might be right.

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our contributors

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John A J Macleod was a GP in North Uist and remains an institution. His house overlooks a narrow gut off Lochmaddy, and boasts a flagpole, which you don't want to look at for three straight days, stormbound, with a dodgy engine
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Prague

THE fortifications of Prague Castle, on high ground above the River Vltava, protect not an ancient, squat keep, but a glorious, soaring, gothic cathedral. The symbolism is clinically precise. The earliest stones of St Vitus's heavenward aspiration date, like the Charles Bridge below it, from the Holy Roman Empire. Spanish Kings sought to establish a pan-European theocracy. Prague was suitably in the middle of their planned Empire of God. Castle and Cathedral announce their divine, territorial ambition.

From its beginnings, there was a Jewish community in Prague. Jews were a problem. A good Christian Emperor could not properly be too cosy with the race that begat and rejected Christ. On the other hand, their interest rates were competitive. The solution was the ghetto, where Jews were regulated and exploited, such that the word came to signify overcrowding, infestation, segregation, and repression. But, there were Imperial funds for a Crusade or two, and later, for wars to suppress the Hussites, professors of an insufficiently Roman brand of Christianity. John of Huss was burned at the stake in 1415. Inquisitions subsequently were up to the same tricks all over Europe, wherever they could get off with it.

In the 17th and early 18th centuries, in the religious fervour following the counter-Reformation, lots of gorgeously elegant baroque churches sprung up in still-Catholic Prague. Outwardly all curves and domes, the modest scale and subtle outlines of these buildings seem to betoken a gentler approach, in contrast with the Gothic heaven hooks; a hint of humanism, even restraint, in place of determination to impress, or intimidate. But inside, the senses are assaulted by forests of swirling gilt ornamentation, from which squadrons of beefy, less than airworthy cherubs threaten theological saturation bombardment. Décor by Tate and Lyle. Nutty cults were fashionable. The very beautiful building of the shrine of Loreto houses a transubstantiated manger, or something like that.

Nor was ecclesiastical progress in 18th century Bohemia confined to interior design. Rather than burning those of whom it disapproved, the Church had taken to breaking men on the wheel. This meant that a chap was attached to a St Andrew-type cross and another chap with an iron bar broke every long bone in his body. Then, in an odd elaboration, the first chap was transferred to a wheel, on which he was hung out until dead, or more dead.

The art nouveau buildings of Novoi Mesto in Prague are reminiscent of the secular, austere, regular, Enlightenment façades of New Town Edinburgh, with a good splash of Romanticism. Here there is not only a sense of pride in an ordered, confident, society, but a generous capacity to enjoy it to the full. In the very early 20th century, coal, steel and capitalism made Prague rich, at a time when the enfeeblement of the Hapsburgs minimised foreign interference. I loved it all. The coffee houses were a delight. It must have been a great time in the city, though less so if you were a provincial miner or furnaceman, I guess.

Much of the old Jewish quarter was raised to make way for the fashionable New Town. We were shown round the remaining synagogues, museums and cemetery by a quietly informative young woman. We were lucky to have her to ourselves, and she was generous with her own family's history. Her father survived Auschwitz, how she did not say. Her mother was hidden by a Gentile Czech family for the duration of the German occupation. Now, her brother is determined to be simply, exclusively, a Czech. She is equally determined to be Jewish and Czech. She said it was hard to keep Jewishness going in Prague, there were so few Jews left. She was critical of the stridency of Israel. Her attitudes and opinions, so far as we had time to discover, were calmly humane, yet … glistened with conviction.

Under the exquisite ceilings of Prague's art nouveau concert hall, we mingled with the great and the good of the city in the interval, sipping something pleasantly white and fizzy. We supposed that many must have had more or less actively communist pasts, stern high priests, perhaps, of the fourth great middle eastern monotheism. Then, Shostakovich's 10th symphony, written in 1953 as the post-war Soviet reality asserted itself in Russia. It is a long, hard, steady gaze into a totalitarian abyss. My tears would not stay back.

In the airport, there is a black-coated, black-suited, black-hatted, black-bearded young man, closely facing a wall, reading with bowed head from a small book. He rocks back and forth rhythmically, as if entranced. I teeter between sorrowing, incomprehending perplexity, and gusts of rage.