The Back Pages

viewpoint

Risk management in general practice

RISK management has been developed by health administrators as a solution to well publicised mistakes. It is most developed in secondary care, where the influence of the NHS litigation authority has produced specific and detailed guidance.[1] However, there is little decided on how it should be introduced into general practice. The National Patient Safety Authority (NPSA) and the Royal College of General Practitioner are to hold a joint conference to explore the issue. The model used for secondary care trusts would be bureaucratic to introduce at practice level and proscriptive for practices if introduced by Primary Care Organisations. Doing the best for patients is key to why we became doctors. How can this initiative be made relevant to the problems faced by GPs?

General practice does not have the reporting and control systems of secondary care. Putting them in place would protect the registered doctor and codify practice, but would it help the patient? Similarly, detailed review after individual incidents can produce beneficial change or overly bureaucratic protocols. Knowing what is expected and having rules for what to do certainly helps in some situations. Depending on the detail of the solution, harm can be done. The Audit Commission recently suggested that control was the reason for the retention problems in the public sector.[2] It is known that increasing control over professionals reduces involvement and increases burnout.[3]

General practitioners are custodians of the medical record and are responsible for prescribing. Any potential problems are the responsibility of the GP who writes the prescription. There are real risks of inappropriate co-prescribing with warfarin, selecting the wrong dose of methotrexate or mixing up proprietary and generic drugs. Problems also arise from interactions between medicines appropriately requested from two or more specialties. These requests often arise outside the practice from specialist doctors and nurses who do not take responsibility for the final prescribing decision. Risk is transferred to the GP.

The registered doctor carries an additional responsibility for those who work in the practice. This was appropriate in the days of small practices when only the GP saw the patient and provided services personally. Things are more difficult in large practices, where the GP is managerially and professionally responsible for the actions of others. In general practice there is clear accountability for error — enquiries in other branches of medicine often seem to conclude that the problem was communication, because no one person was responsible. GP practices cannot do this. This responsibility encourages the GP principal to make sure that the system works. There are both considerable benefits (mostly for the system and the patient) and costs (mostly for the practitioner). This is perhaps part of the reason why general practice has been effective in reducing risk for the NHS.

Risk management traditionally describes risk to the patient. However, there are also risks to individuals within the system. Medical errors can be professionally and personally damaging, to GPs, salaried doctors, nursing and support staff. Unfortunately, it is now a common experience to have to console a damaged colleague after an error. In time, a change to a defensive culture or loss of staff will affect the functioning of the system.

Risks are faced by GPs every working day. I chose prescribing above but analysing investigations or referrals or telephone consultations or follow-up of smear results or ... *ad infinitum*, would be equally apposite in our complex system in these complex times. There is a need for a comprehensive approach to risk management that understands the effect proposed solutions have on individual doctors and the whole system. GPs have accepted the responsibility inherent in holding the prescribing record and in acting as a gatekeeper to secondary care. Risks will increase if GPs become unwilling or unable to coordinate care. This crucial role must be recognised, valued and supported. It is appropriate to look at general practice as a whole to understand how the existing system and expected changes affect risk to patients. This can then be used to judge each prospective solution or design new approaches.

Andrew Spooner

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"He said — he was quite a nice chap from the Gestapo, in riding boots as they always had — he said, 'Well, my advice to you is to go as soon as possible.'"

Freddy Morgan, page 588

"If patients knew that NHS services for a family of four cost around £6000 a year, it would help them judge whether the health service was really delivering value for money ..."

Money — the last taboo
Paul Hodgkin
Postcards 2003-2004, 1, page 582

"Ban smoking in public places."

Advice for John Reid
Dear John, from page 585

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news

RCGP Historical Award

A new award is being launched this year to increase the knowledge of the history of general practice in the UK. The RCGP and The Worshipful Society of Apothecaries of London are launching The Rose Prize, which they hope will stimulate interest and research into the history of general practice.

The award is named after Fraser Rose, a founder member of the RCGP; and William Rose, a 17th century apothecary who helped campaign for apothecaries to be permitted to both prescribe and dispense medicines. It will be open to all who are, or who have been, involved in primary healthcare but are not professional historians. Work must be undertaken in the two years preceding the date of entry, by any number of authors. The first prize will be awarded in 2004.

Work submitted can be in audio-visual, digital or electronic formats, oral history, radio programmes or databases, provided that it contains an adequate element of historical interpretation. Written submissions should not exceed 8000 words. It is emphasised that recent history is just as valuable as older history and could even include topics in the applicant's own lifetime and experience. Submissions that cannot be moved; for example, museum displays, will be considered. The winner will receive a certificate and a silver rose bowl to keep for two years.

Seminar on Refugee Women

THE King's Fund and the Refugee Council are hosting a joint seminar focusing on improving the health of a significant minority — refugee women. Organised as part of Refugee Week, the event aims to raise awareness of the problems facing refugee women in maintaining health and wellbeing in the UK, and also highlight the potential of women refugees to contribute to others' health and wellbeing through, for example, advocacy and health service employment. We particularly want to raise practical ideas that to help both refugee women and the wider community and health services.

We are focusing on women because, as they represent only about one-fifth of the asylum seeking population in the UK, they can often be neglected. Yet they are one of the most vulnerable groups in society, and can often have special contributions to make, from keeping uprooted families together to getting many self-development projects off the ground.

Among the speakers are:

- Rabbi Julia Neuberger; King's Fund chief executive, who will introduce the event;
- Naaz Coker, Chair of The Refugee Council, who will give a keynote address on the needs of refugee women;
- Barbara Roche, Minister for Women and Social Exclusion, who will provide the Government response;
- Berivan Dosky, Director of the Kurdish Housing Association, who will talk from the viewpoint of a former female refugee;
- Peter LeFeuvre, a GP, who will discuss the health care needs of refugee women;
- Jocelyn Avigad, from The Medical Foundation, who will discuss refugee women within their families and their mental health and wellbeing.

The event will be chaired by Shyama Perera, journalist and broadcaster.

The event is on Tuesday 17 June 2003, from 9.00 am to 1.00 pm at the King's Fund, 11-13 Cavendish Square, London W1G 0AN. If you would like to attend the event, then please contact Daniel Reynolds in the King's Fund public affairs office on 020 7307 2581 or 07831 554927. Alternatively, you can turn up on the day.

Daniel Reynolds

Lung Cancer Update

HEALTH professionals interested in lung cancer are expected to gather in Mid Wales next month for a workshop designed to update GPs and nurses about the latest management and treatment of the disease.

The afternoon workshop is being organised by the Institute of Rural Health (IRH) at its base at Gregynog, near Newtown on 9 July, with support from the New Opportunities Fund and the National Public Health Service in Powys.

As the second most common cancer in men and the third most common in women, lung cancer is the biggest cancer killer in the UK. About 38 000 new cases of lung cancer are diagnosed in the UK each year and an average of 94 people die every day. Prevention, management and targets relating to lung cancer have changed during the past few years, and this workshop is aimed at bringing health professionals up to date.

Speakers at the workshop include Jemma Edmonds, smoking cessation co-ordinator for Dyfed and Powys, who will address the issue of smoking cessation in rural areas; and Tim Cooper, cancer services manager at the Royal Shrewsbury Hospital, who will outline changes in cancer services and the implications for General Practice.

New treatments and lung cancer survival rates will be covered by Dr Seamus Linnane, of Llandough Hospital, Penarth, while Trish Langdon, clinical nurse specialist at the Royal Shrewsbury Hospital, will refer to aftercare for lung cancer and Eirian Thomas, community McMillan nurse for Shropshire Primary Care Trust, will speak about palliative care in the community.

The main aim of the New Opportunity Fund project is to raise awareness of the signs and symptoms of male-specific cancer in the community. Mortality from lung cancer has dropped at a slower rate in Powys then the rest of Wales, and the county has the highest incidence and mortality in males and has the second highest incidence for women. It is most common in men and women aged between 65 and 75 years of age.

For more information about the conference, contact Ann Whale, Institute of Rural Health tel 01686 650800, or visit **www.rural-health.ac.uk**.

katya schopflin

I was privileged to be among the relatives and friends of Dr Katya Schopflin at Gissing Hall in Norfolk in March, to celebrate the 86 crowded years of her life. Like other colleagues who had known her when she served on Council between 1974 and 1979, I knew that she had fled from an oppressive post-war government in Hungary, and had had to qualify for the second time as a doctor in Glasgow to practise in this country, which she did to great effect in Stepney before a retirement honoured with an OBE in the late 1980s.

Born in Szepesofalu (then in Hungary, now in Slovakia), she lost her place to study medicine in Budapest when she was arrested and spent four days in prison for illegal youthful political activities. She secured a place at Prague instead, but was prevented from qualifying by the Nazi occupation in 1938. She returned to Budapest to marry Julian, a professional journalist, and together with their two children they survived war and Russian occupation. She attended the Medical Faculty of Budapest University from 1945 to 1947 and eventually qualified as a DM. In 1949 she accompanied her husband when he was posted to Stockholm as Hungarian Envoy Extraordinary to Sweden, Norway and Denmark — an attempt by the increasingly Stalinist Budapest government to avoid his criticisms. After receiving a warning that there was trouble to be expected on their recall to Hungary, when the call came the following year they changed trains in Copenhagen, took the boat to Harwich, and sought asylum in the UK. The ambassador whom Julian had assisted, however, went back to Budapest — and then he had to flee following the failure of the Hungarian uprising in 1956.

After qualifying again in Glasgow and Edinburgh in 1955, she entered general practice in the West of Scotland, before appointment to a single-handed practice in Stepney in east London in 1964. Later, she established a successful teaching partnership practice at Cable Street, her promised new premises turning out to be a Portakabin. Having declared that she would never visit Hungary as long as the Iron Curtain remained, the fall of the Berlin Wall inspired her to drive alone to Budapest in her old Volvo, to see friends and scenes of her childhood. She and Julian eventually retired to live in a cottage at Roydon, near Diss, in Norfolk, where she continued to assist neighbouring practices until her final illness claimed her on 2 January 2003.

All who spoke at the celebration recalled her infectious enthusiasm and *joie de vivre*. The College was honoured to have her on its Council. She was in every way a great lady, and a credit to the profession of general practice.

Roy Aitken

flora medica theophrastus bombastus

From the journals, May 2003

***New Eng J Med* Vol 348**
1737 Two papers on pneumococcal vaccine. It is highly protective against invasive disease if given to infants (four doses), and seems to protect adjacent adults, too. Unfortunately, when given to elderly adults (page 1747), it only protects against bacteraemic disease, not against ordinary respiratory infections.
1839 Now that we can no longer justify prescribing hormone replacement therapy for its long-term benefits, here comes a study that shows that it does not have a 'clinically meaningful effect on health-related quality of life', either.
2007 An update on medical progress in heart failure — good on high-tech interventions, but real progress may come from better communication and organisation of care.
2074 Was Dr Atkins really right about his low-carbohydrate diet? Judge for yourselves — the evidence is slim.
2103 Restless Legs Syndrome is common and wakes people with a jolt just as they get comfortable, like a bad conscience. Quite a few treatments — for legs, anyway.

***Lancet* Vol 361**
1491 Two studies that appear to show that high-fibre foods protect against colorectal cancer. But, as the editorial (page 1487) asks, is this an effect of the fibre or other constituents in fruit and vegetables?
1581 Are new generation antipsychotics really better than old ones? This systematic review finds convincing evidence only for clozapine.
1629 Essential hypertension: a superb summary from a leading expert. Essential reading, too — whether ambulatory, sitting, or a series of readings at different times.
1664 Topiramate is an anticonvulsant which seems to work on the 'addiction centre': here it helps in treating alcohol dependence. The editorial on the subject is excellent (page 1646).
1792 Nearly 10% of army recruits test positive for *Chlamydia*.
1832 At the end of an issue full of brilliant science about SARS, a nicely whacky contribution from a brilliant scientist, Chandra Wickramsinghe. You may remember that he and Fred Hoyle proposed that life originated from outer space. And, yes, that's where SARS comes from, too.
1849 Varicocoele ligation is probably useless as a treatment for male subfertility.
1894 Just how useful is metformin in treating polycystic ovarian syndrome? Lifestyle changes are better, says this review.

***JAMA* Vol 289**
2230 Sleep-disordered breathing: did you know that alcohol and smoking play no part, and that after the age of 60 it is as common in women as men?
2254 Using insulin in primary care: two very useful papers offer guidance.
2363 A look at the prevalence of hypertension in six developed countries: Germany does worst, the USA best.
2387 It's all downhill from now on for some of us, but what do end-of-life trajectories really look like? Interesting charts.
2525 For optimal bone mineral replacement in postmenopausal women, use hormone replacement and alendronate.
2534 A good month for hypertension: here's a big meta-analysis of drug treatment, showing that thiazides are tops.
2651 Three papers from the Women's Health Initiative study of combined HRT, showing a slight increase in cognitive decline, and sufficient stroke risk to abort the trial.

Other Journals
***Arch Intern Med* 163: 1058** deprives us of reassurance to give to men with chronic headache: there is a fourfold risk of stroke over 20 years. A Dutch study (page 1089) shows that influenza vaccine reduces mortality as well as influenza in the elderly. More evidence that fruit and vegetables are good for you (page 1099): high serum levels of enterolactone ('phyto-oestrogen') are associated with decreased vascular disease in Finnish men. ***Ann Intern Med* 138: 795** concludes that the coxibs do not justify their extra cost in most patients with chronic arthritis. An analysis of six big trials of stroke prevention in elderly patients with atrial fibrillation (page 831) concludes that aspirin is best for the third who are at lowest risk.
'So what should I actually weigh, doctor?' — ***Epidemiology* 14: 293** is the place to look. A BMI of 24 is best for old men, and 25.7 for old women. A bit less if you're younger, I'm afraid. In ***Thorax* 58: 339**, tongue-tripping tiotropium trumps salmeterol in reducing exacerbations of chronic obstructive pulmonary disease. ***QJM* 96: 369** is an Australian study of overdoses using antidepressants, confirming that venlafaxine is more dangerous than SSRIs. Hitler, Churchill, Mountbatten, Truman, the Shah of Iran — were they all ill or bonkers? Read page 325.

Plant of the Month: *Rumex scutatus*
Sorrel gives a delicious bite to your summer soups and salads: there are red and silver-leaved forms.

War or health? — humanitarian crisis worsens in war-torn Congo

In some villages the people are living in the most basic conditions and extremely emaciated people are found, locally they are called the 'living skeletons'. This boy is 18 years old and is suffering from severe malnutrition.
Photo: Frida Lagerholm/MSF

Of 16 admissions into the clinic yesterday, the doctor tells us, five children had lost one or both parents. This is but one example of the grim reality facing millions living in today's war-torn Democratic Republic of Congo (DRC), a country in the grip of a devastating war spanning decades, in which death and violence is endemic.

We meet eight-year-old Zarie, now the only one of her family left to take care of her malnourished baby sister. The baby lies asleep, tied onto her back, as she awaits her turn in the feeding queue. Five other children have also arrived at the clinic today with their sick mother, who is suffering from deep grenade wounds to both her legs. The family fled fighting in their village, and spent days and nights in the forest too scared to return and seek medical help. Their father was killed outright as the first bombs dropped on their house. Stories of such human tragedy are commonplace in the DRC; everyone is affected.

Populations living in eastern parts of the country, witnesses to ongoing heavy fighting between armies, rebel factions, and proxy militia, are particularly affected.[1] Physical assaults, torture, sexual abuse, theft, and destruction of property occur with frightening regularity.[2] Thousands live in a state of perpetual terror and motion.

This year, violence has once again escalated around the town of Bunia, Ituri province, near the Ugandan border, following the withdrawal of Ugandan forces. In May, more than 100 000 residents fled in fear of militia wielding machetes, spears, and guns.[3] Massacres and indiscriminate killings were carried out with total impunity. The corpses of men, women, and children lay rotting in Bunia's streets, with aid agencies unable to move securely throughout much of the area to respond to the mounting health and humanitarian needs. Forty thousand people arrived in neighbouring Beni after a two-week journey by foot through the forest, while tens of thousands remain as yet unaccounted for. The likelihood of a major massacre taking place in Bunia in the near future is increasing; the killing continues throughout Ituri at this time. After repeated calls for the presence of an international peace-keeping force, with a mandate to stop the ongoing violence, a rapid-reaction force of French-led UN troops was deployed in June. However, its work is currently restricted to Bunia, initially for three months.

In 2001, Médecins Sans Frontières (MSF) carried out a survey to assess the population's exposure to violence in western and central DRC. In Basankusu,[2] a cease-fire zone occupied by the military, it was found that, between 1998 and 2000, 85% of households had a family member who had experienced violence; nearly 90% had been obliged to flee or were displaced during that time (see Table 1).

Existing health services have long since been unable to respond to the escalating needs. Infectious and diarrhoeal illnesses, malaria, and malnutrition — a pattern of disease typical in such emergencies[4] — remain common causes of death throughout the country at this time, both in and out of areas of direct fighting. The DRC now ranks 179 out of 191 countries surveyed by the World Health Organization,[5] and remains one of the world's least developed countries.[6]

Years of mismanagement and corruption have left health services throughout the country in crisis. Violence and population displacement on a massive scale compounds the situation further still. The withdrawal of multilateral and bilateral aid initiatives since 1992 has left the health system in the sole hands of non-governmental organisations and independent groups. The WHO estimates that up to 75% of the population may have no access to formal health care.[7] The result is high mortality and chronic ill health throughout the country.

MSF has been providing medical assistance in the DRC since 1981. Activities include supervising and training health staff, vaccinations, antenatal care, epidemiological surveillance, and water and sanitation improvement. MSF is working at a grass roots level to ensure continuous provision of drug supplies into the regions in which it works. The destruction of roads and bridges has severely damaged trade networks throughout the interior of the DRC, and thus health centres throughout the country lack basic supplies. Where they do exist, a shortage of paper money in a country whose economy has totally collapsed means that few have any means of buying them. More than two-thirds of people in Basankusu, for example, reported not seeking consultation when they fell ill because they had no money to pay for doctors or medicines.[2]

Perpetual insecurity hinders the initiation of long-term health initiatives. A sustainable approach remains out of the question in a country with neither centralised control nor

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	n (%)
Exposure to violence (n = 912)	771 (84.5)
Theft	596 (77.3)
Destruction of house/field	362 (47.0)
Physical assault	160 (20.8)
Imprisonment	85 (11.0)
Torture	118 (15.3)
Sexual abuse	103 (13.4)
Mines	3 (0.4)
Bullet wound	41 (5.3)

Table 1. Exposure to violence, Basankusu (1998-2000).[2]

a functioning economy. Instead, acute needs must be addressed with the urgency they have long since required. In Bunia, MSF is currently carrying out 15 to 20 surgical interventions a day, mainly for injuries from gunshots or machete wounds, and up to 120 medical consultations. Monitoring of the 100 000 displaced people living in two camps in Bunia is ongoing, with measures being put in place to contain a possible cholera outbreak. No access to the thousands who fled to forest areas around Bunia, and who are cut off from food supplies and health care, is possible at this time.

In other areas, public authorities sent to maintain law and order abuse civilians with impunity as well, presenting as great a threat to the civilian population as the previous military groups. The MSF team in Yahuma, in Oriental Province, has recently witnessed such abuses. Aside from general looting, villagers are used as 'slaves' by the newly established police force. Resistance has led to physical retribution and indefinite detention.

In other more stable parts of the country, infectious disease control and treatment are a priority. Death among children is particularly high throughout the DRC; a collapsed health service means that many are left unprotected from vaccine-preventable diseases, such as measles and tuberculosis. Francine, who presented at the MSF clinic this morning, is one of thousands affected. Skeleton thin, she lies in the examining room groaning and coughing in acute pain as the doctor checks her abdomen. She has not been to a clinic before, she explains, because she had no money to pay. The doctor's diagnosis is advanced disseminated tuberculosis, from which she will almost certainly die. A cruel and unjust end for a child of 12 years.

In recent months, the health and humanitarian situation in the DRC has gone from bad to catastrophic. Continued violence and displacement means that thousands cannot be reached with vital humanitarian assistance. International organisations, falling over each other in Iraq at this time, are notably absent in this forgotten corner of the globe, despite obvious and acute needs. Western governments, who have long since brushed this crisis under the carpet, must stop declaring the situation too tangled to resolve, and act to provide a massive increase in assistance countrywide.

Initiatives that will guarantee the security and protection of the civilian population, and allow improved access of humanitarian aid into areas in and around Bunia, should be encouraged and initiated by the international community and local leaders. It is crucial that humanitarian organisations are allowed free and independent access to assess the scale of unmet need at this time.

This brutal conflict remains, without doubt, one of today's greatest international humanitarian emergencies. Without immediate assistance, the cycle of human misery will continue unabated and the health of the population decline further still.

Sally Hargreaves
Eva Van Beek
Luc Nicolas

john holden

Not the MRCGP

A 60-year-old woman had suffered a stroke in the past, had a hip replacement in 1995, was a heavy smoker, and was known to suffer from osteoporosis, depression/insomnia, angina, hypertension, neuropathic pain, and back pain/osteoarthritis.

She was admitted to hospital with respiratory problems in November 2002 and died four days later. She was on a morphine infusion at the time of her death.

Medication on admission was listed as:

Alendronic acid (Fosamax)	10 mg
Raloxifene (Evista)	60 mg
Promethazine (Phenergan)	50 mg
Temazepam	20 mg
Sertraline	150 mg
Diltiazem MR (Adizem)	120 mg
Aspirin	75 mg
Losartan	50 mg
Atenolol	100 mg
Co-amilofruse	5/40 mg
Isosorbide mononitrate	60 mg
Amlodipine	10 mg
Nicorandil	10 mg
Atorvastatin	10 mg
Ibuprofen MR	800 mg
Paracetamol	2000 mg
Tramadol	300 mg
Gabapentin	900 mg
GTN spray	prn
Four (unspecified) inhalers	
Two 'Kalms' three times daily	

The medical coroner (proposed by the Shipman Inquiry) will investigate possible cases of medical error. What grounds (if any) are there for referring this woman?

A local pharmacist's computer threw up 24 potential interactions. Our St Helens Old Principals Group identified nine possible reasons, based on her medication, for considering involving the medical coroner. The current judicial coroner ordered a post mortem, which led to death being recorded as due to bronchial pneumonia, hypertension, and coronary heart disease.

The Shipman Inquiry's discussion paper, published in October 2002, suggests obliging doctors and others to report deaths to a new medical coroner when there is reason to suspect that medical error may have contributed. Is it not salutary to review some recent deaths and ask whether any errors were ever made in the care of those patients? Our experience of auditing deaths in a confidential small group of GPs for 12 years has been that 'errors' are all too common, particularly when viewed through the distorting lens of hindsight. We think most deaths will need to be investigated.

And the woman? Myra Hindley, whose inquest was widely reported in the press recently.

postcards 2003-2004

Postcards 1 ... Money — the last taboo

Why is it that we never, ever, talk about money with patients?

What course are we steering?

To grey sludge
and doom,
or to sunlit uplands?

Or both?

We begin a series of articles that look forward ...

Paul Hodgkin
Alec Logan

PATIENTS consulting their GP in any other country would find it bizarre if the cost of the service, or at least their own contribution to it, was never discussed. But in Britain mentioning money is taboo. We can talk about sex, death, abuse, even about the mistakes our colleagues make. But never, ever, do we discuss what treatment costs.

As a consequence it is impossible for patients or relatives to judge whether the NHS is delivering good value. It would be quite easy to remedy this; some years ago Roy Lilley suggested that everyone receiving elective care should be sent a letter setting out what the costs of their care had been. (Dear Mrs Archer, We hope you are recovering from your recent operation. You may like to know that the bill for this amounted to £2243 and has been paid in full by the UK taxpayer. Yours, etc., Borchester PCT).

Similarly, it would be straightforward for a practice to display their prescribing costs each month in the waiting room, or for Primary Care Trusts to include brief summaries of average costs in the prospectuses that by law they are required to post to every household each year. Outpatient clinics could routinely post the average cost of attendance, the number of DNAs, and the cost of typical procedures by specialty.

If patients knew that NHS services for a family of four cost around £6000 a year, it would help them judge whether the health service was really delivering value for money.

Taboos are always there for a reason, however. When I suggested to my practice that we offer a simple leaflet about the costs of care to patients, together with a brief questionnaire asking whether they wanted such information, they refused. Giving such information would require ethical approval, as it was research; and was perhaps unethical anyway, since some patients would not want to know.

While both opinions have some validity, the real point is that mentioning money brings to the surface all the contradictions that we feel as agents of both state and individual. Which master are we really serving?

Yet hiding these dilemmas is disingenuous. In all other healthcare systems there is talk about the costs of services — why not in ours?

Patients are not stupid, of course. They know that the NHS does not have unlimited resources and often say, ‘I know there’s worse off than me ...’ In this they are recognising that they do not have unlimited call on the NHS resources, that their personal care is contingent on the resources made available by all of us. This risk-sharing mechanism constitutes the unspoken generosity that lies at the heart of the NHS — you get multiple sclerosis and I share the costs of your care forever. My child gets leukaemia and you pick up the tab. The risk-sharing covers almost everyone in society and contributes massively to the social capital and cohesiveness of the UK — even if its importance to society as a whole remains largely implicit and opaque.

But in the past few years, attitudes to the NHS have changed enormously. If in its first half-century the service was profoundly loved, warts and all, it is now seen as simply not good enough. Generosity and goodwill are being replaced by fears that the NHS is doomed to be second rate. NHS funding is increasing rapidly, but it is entirely possible that, despite doing all the right things, the NHS — and the government — will still be found wanting.

If, as a society, we are to make rational decisions about what sort of health service we want, the fundamental nature of the contract underlying the NHS needs to be widely understood by voters. This means talking about money with patients.

But routinely explaining the costs of care is not the only way to develop the kind of citizen-centred health policy that we desperately need if we are to regain legitimacy with the public. Citizens need good access to up-to-date information from other citizens about their local services. Patient forums (and perhaps PALS) should run electronic discussion lists for all major treatment areas on behalf of their local Trust. Patients referred for cholecystectomy, for example, would receive instructions about how to join the e-discussion for the relevant service at the time of their appointment. Discussion groups would provide citizens with up-to-date details from patients with recent experience of the service, and would be a place to share advice and experiences with others locally. Feedback to the Trust would strengthen the standing and validity of views expressed by patient forums. Hospitals could also run routine web-based questionnaires: at discharge every patient would get both a paper questionnaire about the quality of service, and the web address where the same questionnaire could be filled in, together with relevant list servers. Such information would be an invaluable indicator for managers and clinicians and move the NHS some way to routine grounding that sales figures provide in the commercial world.

Ownership is a key word of the NHS. But

what if we made ownership real? In discussing the new practice-based contract, most GPs assume that this is synonymous with a partnership-based contract, and that partners will go on ruling the roost. In fact, practice-based contracts offer the possibility of a whole range of new legal entities through which to provide primary care. Practices could choose to really make ownership real and, like the proposed Foundation Hospitals, set up companies limited by guarantee in which patients could buy a £1 share entitling them to vote about specified aspects of the practice. A recent proposal from the Centre for Policy Studies suggested that organisations somewhat similar to this could also become owners of the property from which the practice operated.

Lack of capital has long been a problem for the NHS, and one of the appeals of PFI is to find new ways outside direct Treasury control through which to raise capital. But what would a mutual model of raising capital look like? In the United States it is commonplace for communities to raise capital bonds to rebuild schools and other facilities. These are financed through a variety of local taxes approved via local referenda and paid back over an agreed number of years.

It would be quite possible to raise capital for the health service in this way. To avoid increasing inequities, any local bond would need to cover populations that included both rich and deprived areas, but this in turn could reinforce the identity of the whole community. Once raised, the 6% return on capital currently paid by the NHS to the Treasury would be recycled to the local community for further investment in public services.

The tension between giving citizens the chance to raise money for local services and the inequities of a 'postcode lottery' for care would, of course, remain. However, better health services would then be clearly linked to higher local taxes, increasing both transparency and democracy.

These measures go far beyond the important but limited moves for 'user involvement', and take the interests of citizens as central to how the NHS is structured, owned and run. They create the cultural and legal apparatus by which citizens — as opposed to managers, clinicians or politicians — begin to feel that the NHS is their own again. And they build new mechanisms through which the tensions and paradoxes of providing health care can be articulated locally by the non-professional citizenry.

Paul Hodgkin

roger neighbour *behind the lines*

On caring

STANDING for election, like knowing one is to be hanged in a fortnight, concentrates the mind wonderfully. The nomination form for the 2003–2006 RCGP Presidency called for a manifesto, a summary of one's ambitions for the College, in not more than 100 words. Given that I've taken nearly 15 000 words so far in these columns sounding off about what I think is good and bad about general practice, the College and the political context in which we live, breathe, and have our struggling, a mere hundred should have been easy. But actually it wasn't. 'Cut the crap', the form seemed to be saying. 'Ditch the funny stuff. Tell us what you really believe'.

So I tried; and rediscovered that saying what you're for is harder than saying what you're against. And telling it straight is harder than telling it funny. 'The President's job is to give a lead on values', I wrote, after much agonising. 'Mine are uncompromisingly those of the consulting room, where individual doctors bring knowledge, resources, insight, experience, and commitment to the service of individual patients. The challenge for the College and the NHS is to preserve consulting-room values in the face of short-term political expedients and the over-regulation of professional judgement'.

Yesterday I learned the result of the ballot. I am to be your next President, succeeding Dame Lesley Southgate, who has achieved great things as a personal doctor, an academic, and an arbiter of high-quality practice. Two four-letter words about sum up my immediate reaction, the first being, 'Gulp!' Huge is the honour, and huge the responsibility. And huge are the opportunities to secure for personal doctoring the recognition it deserves as the embodiment of all that is good, and sound, and worthy, and thoughtful, and cost-effective in delivering care to the nation's unwell — who are, after all, the friends and neighbours and relations of us all.

Then today I remembered that I need to get my copy together for the July Back Pages. And dammit, the urge to be up front about what I believe is still with me. But how to do it? Nothing more undermines the sense of humour than the prospect of having to put one's performance where one's mouth is. And (as any columnist will tell you) principles that cannot be expressed are hardly worth having. I think it all hinges on this word 'care'.

What a complex and two-faced word 'care' has become. In Orwell's *Nineteen Eighty-Four* the Ministry of Love was in fact the agency for imposing repression. Similarly, care — at least when the word is bandied around by those state agencies charged with lowering voters' expectations — is all too often the smiling face of indifference. In disgracefully many official documents, bunging the word 'care' into titles and text is calculated to press a positive response button, much as claiming to have hit your head is the way to fast-track your sprained ankle through A&E, or professing green sputum guarantees you antibiotics for a cold.

Of course patients deserve to receive good, focused, evidence-informed clinical care — the better the better. If quality agendas and targets and new Contracts will achieve this, more strength to their bony little elbows. But I think patients want to be more than the recipients of formalised care bestowed upon them by a state machine desperate to be perceived as competent: I think they want to be cared for. More importantly (and least quantifiably), patients want to be cared about — cared about by the doctors who care for them. There is a risk in the latest attempts to redefine good practice that pursuit of the abstract noun 'care' could come to substitute for the active verb 'to care'. The equating of caring with care could invalidate the balance sheet where the value of general practice is determined.

In Peter Shaffer's 1973 play *Equus*, there's a moment in which Martin Dysart, a child psychiatrist close to burnout, is confiding in his magistrate friend, Hesther. 'Of course', she says ironically, 'I feel totally fit to be a magistrate all the time'. And he replies, 'No, you don't — but then that's you feeling unworthy to fill a job. I feel the job is unworthy to fill me'. How dangerous it would be if the 'Dysart doubt' were to become widespread in general practice. What a tragedy, if a rising generation of GPs were to find that professional life in a target-driven culture that sets too high a premium on slavish delivery of formulaic care proved insufficiently worthy of their intelligence and devotion.

For everyone's sake, primary care, and our College in particular, must continue to champion the primacy of caring. *Cum scientia calculatio*? I don't think so.

Personpower planning

It took us some time to find a new partner for an innovative market town practice in an attractive part of South West Scotland. There are similar problems in the rest of the country, from the Western Isles to inner London, where it is estimated that five hundred more GPs will be required by next year. Twenty years ago there were concerns about medical unemployment, with no vacancies in the West of Scotland for one third of those being vocationally trained[1] in the area.

In 1944 the Goodenough Committee wisely refused to forecast doctor numbers, beyond saying there would an increase with the introduction of the NHS. Medical student intake at that time was about 2000 a year and in the 1950s there was competition for jobs. As a result, the Willink Committee recommended a reduction of medical student intake to 1760 a year. The effect of this was seen in the 1960s when the shortage of doctors was met by an influx of those trained overseas. The pendulum then swung back again with the Todd Report in 1968, which recommended increasing the medical student intake to 4500 a year.[2]

The problem of estimating future needs for doctors has been hampered by inadequate information[3] and by the fact that it takes nine years to train a general practitioner, by which time many things will have changed in terms of demography, medical advances, and health service politics. These difficulties were highlighted by a Government report in 1978 on ‘Doctor manpower 1975–2000’, which offered three guesses for the necessary increase in doctor numbers by the year 2000, ranging from 11% to 52%. At that time there were about 66 000 doctors working in the NHS and of those about 18 000 had qualified overseas, the majority from the Indian sub-continent. This represented one-third of hospital doctors and one-fifth of general practitioners. The number of overseas doctors granted full registration has since fallen,[4] against a backdrop of increasing numbers of doctors from the European Union coming to work in Britain.

The other side of the coin is the number of British medical graduates who have emmigrated, but these numbers have been decreasing since the 1970s when the governments of America, Canada, Australia and New Zealand began restricting entry, owing to concerns about surplus doctors. There were similar problems on the continent where the number of doctors in France had doubled between the years 1960 and 1976, and in Spain they had quadrupled in the previous decade. Compared with other European countries in the 1970s, Britain had the fewest medical students per head of population in Europe, with Belgium, for instance, having six times the number of students and twice the number of doctors. In short, all western European countries were experiencing substantial medical unemployment and steps were taken to cut medical student intake. At the time the growth of medical education was a worldwide phenomena, with the number of medical schools in the world having doubled in the previous decade.

In 1982, the number of unemployed doctors had increased to 1500 and the British Medical Association was recommending a cut in the student intake to avoid substantial medical unemployment by the turn of the century. In 1989, the BMA estimated a threefold increase in the number of doctors between the years 1950 and 1987 in the European Community, amid concerns about the resources available to keep this number working. Between 1980 and 1990 the total number of general practitioners in the UK increased by 17%. By the 1990s, measures were being taken to reduce the medical student intake in all European countries owing to unemployment, and there were concerns in the UK that the numbers of general practitioners were outstripping population growth. However, the Medical Manpower Standing Advisory Committee, set up in 1991, recommended a 5.7% increase in medical student intake in the UK,[5] although health economists, such as Alan Maynard, were claiming that this would lead to doctor surpluses in the early 21st century.

By the late 1990s there was increasing evidence of problems in recruitment and retention for general practice. Some of this was put down to pressures from the new contract, with more part-time working and a decline in morale leading to earlier retirement, which had been made easier by changes in pension regulations. In addition overseas doctors were retiring and not being replaced, especially in inner-city areas. As a result, the third report of the Medical Work for Standing Advisory Committee in 1997 recommended an increase of about 1000 a year in medical school intake (20% increase) to meet growing demand and reduce reliance on doctors trained overseas.[6] In the Trent region, where there used to be up to 100 applicants for each post, there

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were about ten in 1994, which was partly put down to the effect of the new contract with increasing workloads and decreasing morale.[7]

A major underlying factor has been the dramatic drift in gender balance in the medical profession. In the 1960s, many medical schools admitted a quota of about 10% female students, whereas now, with equal opportunities, over half of all medical students are women, as are registrars in general practice. This places an emphasis on more flexible working patterns with job sharing and part-time work. By the mid-1990s one-third of women general practitioners were working part-time.

In response to these problems, medical education in the United Kingdom is currently expanding, with five new medical schools due to be open by 2005 when 6873 medical students will start. This is a 31% increase from the year 2000 and a 58% increase from 1995. However, the number of applicants is not rising at the same rate and if numbers stay the same there would be a selection ratio in 2005 of 1.18, which means supply barely meeting demand.[8] Another problem is that the proportion of medical graduates deciding not to go into clinical practice appears to be rising, while at the same time general practice is decreasing as a career choice, with only 20% of newly qualified doctors intending to enter general practice in 1996, compared with 40% to 50% in the 1970s and 1980s.[9] A similar decline in family medicine as a career choice has been noted in America.

Even if the supply of medical graduates increases in the next few years there is an immediate problem, with the number of unfilled GP vacancies last year having doubled and over a hundred remaining empty for more than a year. There is currently a 3.4% vacancy rate in England and Wales with the number of applications for GP vacancies halving in the past two years. In Scotland the number of GP vacancies has doubled with the number of full-time equivalent GPs having fallen for the first time. More than one-third of GPs in Scotland are female and 20% of the workforce now work part-time. More than a quarter of GPs in Scotland are over 50 and the majority are considering early retirement. This is at a time of increasing demand with consultations in the year 2000 in Scotland passing one million, an increase of 17% from the previous year. The NHS plan has a target of 2000 new GPs by March next year, but it is difficult to see where all these doctors will come from.

The term 'personpower planning' is more appropriate than 'manpower planning' when over half the potential workforce are women. This is not just a case of political correctness, but rather of attitudes towards working careers. Priority needs to be given to flexibility for part-time work and job-sharing.[10] with career breaks for family and other reasons, not just for women but also for men. In particular, there needs to be a recognition of the problem of joint careers, particularly in rural areas. A major disincentive for the majority of potential applicants to rural practice, who are mainly female, is that there are no jobs for their partners or spouses, unlike in urban areas.

Over the past generation medical manpower planning has been like some lumbering oil tanker nine years in length, tossed about in a sea of change, both political, medical and demographic. The ship has veered one way towards increasing numbers of medical students in the 1950s, and then back to cutting down in the 1960s and 70s amid fears of unemployment, and now back again to expansion because of the lack of doctors.

Personpower planning needs to be able to adapt more quickly to unpredictable sea changes on its voyage. This could be done by shortening the length of the ship to five years, by making clinical medicine a postgraduate training as in North America. This could follow a basic degree in health sciences from which students could choose a number of health-related careers, of which clinical medicine need only be one. Another advantage is that students would be older and more able to make informed choices about careers. School leavers are at an age when girls are more likely to perform better than boys, both academically and in terms of presentation. Starting clinical medicine later after a basic health sciences degree, would give young people more time to have a clearer idea of where they want to go in terms of careers and family commitments. A shorter training period for an older age group with more flexible careers would do much to make personpower planning a reality in the Health Service, rather than a series of expedient lurches from one direction to another.

David Hannay

dear john ... 1

All of a sudden, from 12 June, the UK has a new Secretary of State for Health, Dr John Reid. His constituency is a favoured stomping ground for your Deputy Editor's dog. Dr Reid has some stiff challenges ahead, and pithy advice will doubtless be welcome...

The foundations of the NHS were I believe drawn up in Wales. Lloyd George envelopes were the prototype of a lifelong medical record and Bevan's plumbline of 'free at the point of care' are enduring core values. Continutity, effective-ness and equity, good solid footings. But I think they are disappearing. We have four NHSs, fragmented primary care, escalating demand fuelled by a society in the grip of medicalisation, and our patients are voting with their cheque books in the face of hopelessly long waits for overburdend hospitals. You will of course, make more changes and find more money, but it will never be enough. Society needs to define the limits of medicine, or we will bankrupt our future generations.

Glyn Elwyn
Professor, Primary Care Group, University of Wales Swansea.

Your department wastes a fortune on icebreakers attacking the iceberg. Why not raise the temperature of the surrounding ocean so that it just melts away?

Peter Davies
General Practitioner, Halifax.

Lighten up. Accept that government can never impose perfection. Trust professionals (within wide limits) and give them room to breath. Read *The Paradox of Progress*. Please.

James Willis
Writer and general practitioner, Alton.

Don't meddle in the NHS. Leave it to those who know what they are doing. It should be a politician-free zone.

Rhona MacDonald
Editor, BMJ Careers

digest

Annals of Family Medicine
A new US family practice journal

It might be thought that 2003 is not the best time to launch a new academic primary care journal, particularly from a base in North America. According to the editor of the *Lancet*, 'Many primary care doctors will find more of relevance to their working life in the pages of personal finance magazines than in their own medical journals'.[1] The deputy editor of the *BMJ* thinks that 'specialist journals look like they're on the way out',[2] while primary care in the US is also undergoing a period of introspection and self-examination about its role and functions in the 21st century.[3]

Set against the changing world of medical publishing and ill-disguised antipathy of some general medical journals to primary care research,[4] a new specialist primary care journal has been launched — *Annals of Family Medicine* (www.annfammed.org). Are the editors and publishers of this new journal likely to succeed, given the considerable uncertainty with regard to academic biomedical publishing in general, and the worries about the direction of primary care research in particular?

On reviewing the first edition, my feeling is that the editors have done a good job of convincing me that high-quality primary care journals do have a future. *Annals of Family Medicine* has been endorsed by all of the key educational and research organisations in North America. However, it is not these endorsements, nor indeed the appearance of the printed version (which I feel has a slightly 'dated' look) that has impressed me. The first edition is notable because it presents well written and well conducted primary care research, albeit within a North American context.

In the first edition, there are five original research papers with a significant breadth in terms of clinical and research relevance. An observational study showing that single-disease focus is not a sustainable or effective strategy when managing chronic disease in the community, appreciation and understanding of co-morbidity being the key; a qualitative study which successfully outlines the barriers to self-care; two randomised controlled trials — evaluation of a decision aid for prostate cancer screening and a trial examining alternative management strategies for maintaining glycaemic control in type 2 diabetes; and a cohort study examining the factors associated with the low caesarean section rate in Native American women. There is also a methodology paper that proposes a risk-adjustment framework for measuring primary care performance. An accompanying editorial has contextualised some of the original research papers and the methodology paper in terms of the current challenges to family doctors in North America. All articles are well presented, clear, and balanced.

In terms of the format, the print version is accompanied by an electronic web-based publication that is free to all. The website interface is supported by Stanford University Libraries' Highwire Press, so the format will be familiar to visitors to the *BMJ* website. Downloading of PDF files is easily accomplished and references can be readily placed on reference management software. The editors intend that *Annals of Family Medicine* be used to support a 'learning community of those who generate and use information about health and generalist health care'. To this end they have explicitly promoted discussion through an innovation called TRACK (Topical Response to the Annals Community of Knowledge). Comment on original papers and an open discussion forum is being facilitated by these developments.

The editors of *Annals of Family Medicine* have clearly done their homework in terms of making their journal accessible to readers. Changes in online publishing have been greatest in the correspondence pages of medical journals; the *BMJ* publishes less than 10% of its 'rapid responses' in the print publication;[2] while over half of all online sessions end with a full-text download.[2] *Annals of Family Medicine* also has a section given over to essays or reflections by clinicians, patients, families, and others. In this edition, an article written jointly by a family doctor and a patient, on the experience of dealing with a diagnosis of metastatic lung cancer, made for informative and illuminating reading.

Though many journal editors feel that we are only at the starting point in the technological revolution, changes in medical publishing have not been as substantial as first thought.[2] Nonetheless, there is little doubt that medical publishing is an increasingly competitive environment and that the pendulum of power and influence is swinging away from journals back towards researchers and readers. With these developments in mind, *Annals of Family Medicine* have done an impressive job with their first edition. As a reader and researcher I will be very happy to support this new journal and have added the URL to my bookmarks. I'd urge you to do the same.

Tom Fahey

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Dead Cities: A natural history
Mike Davis
The New Press, 2002
HB, 288pp, £16.95, 1 56584765 2

At the beginning of his essay on the graft and secrecy surrounding the development of the financial centre of Los Angeles, Mike Davis describes the nightly gathering of homeless men, dragging old chairs, to sit and watch the sunset reflected off of '26 million square feet of prime corporate real estate' in downtown LA. This image is one of many which pepper *Dead Cities* with an extraordinary power to 'see' the data contained in Davis' thoroughly researched collection.

Another is the solitary illegal Mexican immigrant selling bags of overripe oranges, for two dollars a bag, all day on a street in a 'city' of Vernon, which has a permanent population of 90 and a daily migrant population of 48 000. Contained within the city of LA, Vernon is a collection of low-rent factories where frozen Chinese food is prepared in buildings next to toxic waste incinerators.

Then there is the 'Hollywood Sinkhole', a collapsed LA subway excavation in the middle of a busy street. Despite breathtaking cost overruns, the LA subway project soldiers on, boring holes under land in the most active tectonic faults in mainland America.

He describes the work of photographers who have made the ruined land at nuclear test sights and abandoned biological weapons centres testimonials to what mankind leaves in its wake. Phillip K Dick, famous for his post-apocalyptic novels, couldn't, in his darkest moments, conjure places that Davis has found in the American West, particularly in its cities.

In the preface, The Flames of New York, Davis uses the HG Wells 1908 book *The War in the Air*, which presages the destruction of a large city, as an entrance to the effects of 11 September on the subsequent 'globalisation of fear'. The range of references that Davis brings to the essay is truly remarkable. He sees connections between writers and events that leave the reader amazed.

Davis is a good scientist, observing things others of us might overlook, and links his observations to social history and economics. For example, he drives around the test grounds in Utah where, during World War II, army engineers constructed German and Japanese housing on which to test incendiary weapons in preparation for the future firestorms of Tokyo and Dresden. Science, it seems, is as essential for mass murder as it is for saving lives.

Davis has the ability to write with passion about the interaction of extra-terrestrial bodies, such as meteors and asteroids, with plate tectonic theory and the origins of the Earth. Although we take both asteroid extinctions and movement along fault lines for granted these days, Davis points out it was less than 50 years ago that we knew either theory. In the title essay, he describes, from fictional writings and from the realities of bombed out London and Berlin in the 1940s, the strange incursion of previous exotic species of plant and animals into the burned and battered landscapes of urban blight. His essay ends with a searing description of the planned 'urban renewal' of the South Bronx in New York through fire, racist housing, and neglect to become the urban wasteland favored symbolically by both conservative and progressive US politicians, as either evidence of government failure or a call for government solutions. In either case, little has changed.

Some of the essays in *Dead Cities* focus in too much detail on the arcane politics and money in urban California, but, throughout, Davis presents ferociously erudite expositions of the abuse that humans have perpetrated both on each other and on the delicate ecology of the American Southwest.

He writes with an eye to the absurd as well. Not many social historians would see the beginnings of the 1960s revolution in a teenage riot about drag racing rights in San Diego. He gets us to see the duck-tailed, leather-coated James Dean wannabes as the anti-establishment stirrings that swept the country. He spins the urban youth riots that started Southern California into an urban rebellion of working class youth that became the black and Chicano riots of the mid-1960s and on into the riots of the early 1990s.

The truth is, I have always said, and mostly believe, that things in the US start in California and move inexorably east — a reason to keep that state in your rear view mirror.

And for that reason alone, we should keep our eye on what Mike Davis is writing these days.

John Frey

dear john ... 2

Go back to the negotiating table with the Consultants or you'll sink!

Marjory Greig
Consultant Microbiologist, Chichester.

Ensure primary care gets the people and resources it needs. Keep devolving to the frontline. Make 'doctors and nurses in the driving seat' a reality.

Michael Dixon
Chair, NHS Alliance.

Remember NHS staff are your coalition but can easily turn into weapons of mass destruction if you turn a deaf ear and a blind eye.

Harvey Marcovitch
Consultant Paediatrician, Banbury.

Your patient, NHS, is in a critical condition and needs transfusion, some surgery and powerful pharmacology. Above all, however, it needs to be listened to, not shouted at.

Brian Keighley
General Practitioner, Balfron.

Considering its popularity, complementary medicine is under-researched and needs clearer research priorities. The important questions concern efficacy and safety, not attitudes, prevalence or other politically correct stuff. Good luck!

Edzard Ernst
Professor of Complementary Medicine,

reflection

Dr Freddy Morgan's story

Freddy Morgan went to medical school in Bohemia in 1930. He has not yet retired, though gave up skiing recently after a new hip. He has recently taken up scuba diving.

WHEN Munich intervened in October 1938, it spelled the end of Czechoslovakia. The whole surrounding area was taken over by the Nazis, and the Protectorate — Bohemia, Moravia — was not viable. In March 1939 the Nazis marched in.

I lost my job in the hospital, unpaid as it was anyway. I came to England because of my Youth Hostel connection. I had been to Youth Hostels in Belgium and Holland in 1935 and there got to know a Scottish medical student, Louis Finlay, who arrived with his friend Jack Watson, an Australian of Scottish descent who wore a kilt. I had kept in touch with Louis ever since.

When Munich happened, he wrote to me and said, 'If there's anything I can do, I will'. His father, Professor Adam Fife-Finlay, was Professor of Theology, in Aberdeen. He was one of the 'Wee Frees'. He offered the sum of £1000, which must be at least £40 000 nowadays, to guarantee a transit visa for me. And then he got a friend who had never even heard of us, another professor at Aberdeen called Cruickshank, to do the same for my brother.

I had to go to Prague for my visa. A very nice lady at the Embassy told me that my brother was lower down on the list; she would put him next to me, which would in turn help me.

We had to go through a tremendous round of applications to the Nazi authorities for permission to emigrate. They had to come and look at our books, to search for any subversive literature. We had to pay for every handkerchief we took out of the country; my parents had to pay *Reichsfluchtsteuer*. 'Reich' is self-evident, 'Flucht' is flight, and 'teuer' is a tax. A tax for fleeing the Reich! We already had had to surrender to the Nazis any watches, rings, jewels of any description, and wireless sets.

And then I had to get a permit to leave. Perhaps rashly, I went to the local Gestapo — it was a nice hot summer's day, I had shorts on, and I was sunburned, and had blond hair and blue eyes, and I said, 'I'm Jewish and I have the opportunity to emigrate, what is your advice?'

He said — he was quite a nice chap from the Gestapo, in riding boots as they always had — he said, 'Well, my advice to you is to go as soon as possible.' I had to queue every morning at four o'clock at an office — fortunately it was summer — to get a signed permit to emigrate.

And then one Saturday morning, there was a Reichs German there, who I think just for effect, shouted, 'You come and trouble me here on Saturday! Here it is.' And there was the permit. I believe it had been there all the time. And I think the shouting was just to mask the fact that he did had done something moderately kind.

We left Brno in August 1939. My brother and I had shorts, and a rucksack, and ten marks in our pockets. And my parents, in order to support the German economy, had to buy our tickets on the Hamburg–America HAPAC Line and we had to go on a German ship. It was an emotional scene at the station. I suppose I just took it in my stride. My brother, who had more foresight and more feeling — he was also a doctor — started to cry and said, 'We are never, never going to see our parents again'. We never did see them again.

We travelled by train from Brno, through Bohemia and came to the German frontier of the Protectorate where they had customs officers. He looked at my passport, which had a big J for *Jude* — Jew — and he looked at me and said, '*Nicht ein Jude* — you are not Jewish'. And I said, 'Yes I am'. But he just shrugged his shoulders and let us go on. We went from the Hook of Holland to Harwich by ship, on a lovely, very calm day across the Channel.

Then we stayed with a friend of Louis Finlay's, Miss Simmons. Louis Finlay had been appointed to take charge of a large Emergency Medical Service sector, completely by mistake. He was a comparatively junior doctor, and they had mixed him up with a very well-known consultant, who was apparently on the high seas somewhere. But he did so well that they then confirmed his originally erroneous appointment.

I remember it all so well — Mr Chamberlain speaking, and then war being declared. We were quite certain about what was to come. It was otherwise rather depressing, because the winter was quite severe. The weather in the Czech Republic was much colder, but it was a dry cold. London was cold and damp. I had never had chillblains before.

We were very fortunate in a way. Miss Simmons was the head dietician at the Hammersmith Hospital — she had been treating the King for his duodenal ulcer. My brother and I went to various lectures at the postgraduate school at Hammersmith, which was an excellent establishment; I felt it was the very best medical school in Britain. I was very pleasant; the people were very friendly, and I suppose they felt sorry for us. There were people there who were destined to become famous in their own right. There was Bywaters, who later became Professor Bywaters, 'Sharpy' Shaeffer, Paul Woods the cardiologist, Braine, who was a dermatologist, and I met Newman, who was the secretary.

We didn't realise until later that everybody else had to pay to attend the lectures, but my brother and I just went anyway. We had no

money to pay, but they very kindly closed not just one eye, but both eyes, and we could just go and meet all of these very eminent people. They were very good to us and very indulgent, and we were able to sit in and listen and try to learn about British medicine. It was a a great education to see British medicine at its best.

We joined up with the Pioneer Corps as privates in 1940, because in those days the BMA was very strict and would not allow doctors with foreign degrees to practise. A very small number of highly qualified German and Austrian physicians were allowed to take examinations and had the right to practise, but my brother and I were not in this league. But we were delighted to be in North Devon, and to do lots of marching and rifle drill. We were digging up golf courses to defend against troop-landing aircraft and gliders. It was a gorgeous summer, called the *Hitlerwetter* — perfect weather for Hitler's tanks to roll across France. I volunteered for guard duties, and in the daytime I went swimming in the sea at Westward Ho!

I was sitting in the NAAFI canteen, having a cup of tea, and the manager said, 'What do you think is going to happen next?' The Nazis had just broken through to Abbeville on the Channel coast, and encircled the British army. And I said, 'Well, it's very serious'. 'Ah', he said. And it stuck in my memory ... I can see him now. He said, 'You know what we are going to do?' That was in May, going on June 1940, when the British army, defeated, and weaponless, were streaming back, by the grace of God, from Dunkirk. He said, 'Now, we are going to invade the Continent.'

And I was delighted to hear it, because I felt that British public — bless them — in their complete ignorance and lack of education, were marvellous to behold. The fortitude and knowledge and courage of Churchill, combined with the ignorance of the general population and their stalwart determination — 'We are British, they can't do anything to us' — that combination was invincible. They had only a shred of the education of the German working class, and of the whole European community, which was so certain that Hitler was going to win, and of course to any sane person on the Continent it seemed to utterly inexorable. Well, Britain would have been done for, but for the fortitude of the British population, and Churchill.

The Pioneer Corps (the Auxiliary Military Pioneer Corps) was an exhilarating experience, with interesting group of people. Some were highly educated; others were from the poor parts of Berlin and Vienna. We had fellow soldiers from the Berlin and Vienna Philharmonic Orchestras — all privates together — marching, digging, and drilling. Next, we found ourselves playing the roles of medical orderlies. The CO had a duodenal ulcer and he was bleeding, so we had to watch over him at night, but mostly it was dressings.

When Britain saw the imminent danger in 1941 my qualification was suddenly, mysteriously, recognised, and I entered the Wartime Medical Reserve. I worked at the Royal Devon and Exeter Hospital, and afterwards at the EMS Hospital in Exminster, near Exeter, a very large mental hospital where half the mental patients had been set to one side to make way for air-raid casualties and patients from the armed services. In those days I had a bicycle, which, I believe, had cost eight shillings. My then girlfiend (now my wife) bought it for me. I used to cycle down to Dawlish Warren, and swim in raging seas between tree trunks and iron stakes, which were placed on the beach to stop troop-landing aircraft. And that was, to my simple mind, wonderfully exhilarating after working hard all day in the hospital.

At night, again and again, we could hear the bombers — the German engines were unsynchronised. I remember I was having a bath, and the Nazis dropped a bomb which killed some of our services patients. I got out of the bath and went straight to the operating theatre. I had nothing on except my dressing gown. The nurses were highly amused, and made me a sort of loincloth, and we operated all night.

I became very restless there, because I felt I must do more. So I volunteered for the Navy, because I loved the sea, and the Navy refused me because I was not of British descent. Similarly, the Air Force said no. Then I volunteered for the Army, and the Army had me straight away. After basic training, we were sent on a special course in tropical medicine. I was friends with another officer named Bushell, who was ex-St Mary's. We used to go running through London every morning before the lectures, along the Thames from Millbank across Lambeth Bridge to Lambeth. Then I was posted the Second Battalion of the King's Shropshire Light Infantry in Dorset, which I thoroughly enjoyed. Dorset was beautiful, and particularly lovely in spring, with its long barrows and short barrows, and — I'm rather romantic — we did route marches at night in this magical setting.

At the time I thought ... Well, my name was going to be published in the official gazette. It's an unusual name, a German name — Morgenbesser — so while I hoped my parents were still alive, I thought it might be safer for them if I changed it. It was shortened to Morgan, and it has stuck ever since. I might very easily go back to Morgenbesser, eventually. I did not know that my parents were by then dead.

Freddy Morgan
Stefan Cembrowicz

dear john ... 3

Peninsula Medical School, Exeter.
Do nothing until you have visited some ordinary surgeries, seen what we do, and listened to our views. Reflect on the conflict between individual and population care.

Toby Lipman
General Practitioner, Newcastle.

NHS spending now amounts to £80 billion*, but that figure — if we should judge the NHS by it — counts primary care access facilitators and teenage pregnancy liaison workers. It counts special administrators to measure waiting targets. It counts IT consultants and directors of partnerships, clinical governance leads, and prescribing advisers. It does not measure the health of its workers, the quality of their education or the joy in their work, or the anger in their frustration. It measures neither wit nor courage of managers and staff, compassion nor devotion. The sum, in short, tells us everything about the NHS except why we are proud to work for it.

James Cave
General Practitioner, Chieveley, Newbury.

The success of the NHS doesn't depend on foundation hospitals, but on getting primary care right. Read Starfield, and reflect a bit.

John Gillies
General Practitioner, Selkirk.

Despite his image of being as hard as his constituency's steel, he has interests in rural health which emerged during an official visit to Lochmaddy (1988).

John AJ Macleod
General Practitioner, Lochmaddy.

Ban smoking in public places.

Richard Watson
General Practitioner, Cambuslang.

**With apologies to Senator Robert Kennedy. This is exactly the same as the GNP of the USA in 1968 when he made the speech.*

The RCGP and Boots The Chemist Research Paper of the Year 200

The Contenders ...

- Grant C, Nicholas R, Moore L, Salisbury C. An observational study comparing quality of care in walk-in centres with general practice and NHS Direct using standardised patients. *BMJ* 2002; **324:** 1556.
- Greenhalgh T, Hughes J, Humphrey C, *et al*. A comparative case study of two models of a clinical informaticist service. *BMJ* 2002; **324:** 524-529.
- Butler CC, Robling M, Prout H, *et al*. Management of suspected acute viral upper respiratory tract infection in children with intranasal sodium cromoglicate: a randomised controlled trial *Lancet* 2002; **359:** 2153-2158.
- Little P, Barnett J, Barnsley L, *et al*. Comparison of agreement between different measures of blood pressure in primary care and daytime ambulatory blood pressure. *BMJ* 2002; **325:** 254.
- Free C, Lee RM, Ogden J. Young women's accounts of factors influencing their use and non-use of emergency contraception: in-depth interview study. *BMJ* 2002; **325:** 1393.
- Lewin RJP, Furze G, Robinson J, *et al*. A randomised controlled trial of a self-management plan for patients with newly diagnosed angina. *Br J Gen Pract* 2002; **52:** 194-201.
- McKinstry B, Walker J, Campbell C, *et al.* Telephone consultations to manage requests for same-day appointments: a randomised controlled trial in two practices. *Br J Gen Pract* 2002; **52:** 306-310.
- Memel D, Langley C, Watkins C, *et al*. Effectiveness of ear syringing in general practice: a randomised controlled trial and patients' experiences. *Br J Gen Pract* 2002; **52:** 906-911.
- Summerskill WSM, Pope C. 'I saw the panic rise in her eyes, and evidence-based medicine went out of the door.' An exploratory qualitative study of the barriers to secondary prevention in the management of coronary heart disease. *Fam Pract* 2002; **9(6):** 605-610.

... And the Winner is:

1. Cappucio FP, Oakeshott P, Strazzullo P, Kerry SM. Application of Framingham risk estimates to ethnic minorities in UK and implications for primary prevention of heart disease in general practice: cross sectional population-based study. *BMJ* 2002; **325:**1-6.

The mission of the RCGP is to support its members to deliver high quality care to patients, and to win and retain respect for the discipline of general practice. To do this effectively, we also have to educate others for best practice and to expand and apply our knowledge base. Research is how we establish new knowledge, and dissemination of new knowledge occurs at first through publication. One of the ways we can stimulate research is through recognising excellent articles, and this is the basis for the RCGP/Boots The Chemists Research Paper of the Year award.

The RCGP and Boots are now entering the seventh year of this prestigious event, and the number and calibre of potential recipients reflects the exponential growth of UK-based primary care research. The authors must include a contributor who is actively involved in clinical general practice, and the panel base their decision on the following:

- how original is the research (new angles on the field, different methods);
- how applicable it is(implications for clinical practice in primary care);
- what contribution will the paper make to the standing of general practice and academic profile thereof (quality and robustness); and
- overall presentation (coherence, communication).

The panel that selects the award winner reflects the current state of primary care research: multidisciplinary, service and academic practitioners, researchers with different interests, and preferred approaches. It is inclusive in its approach: papers can be nominated by any individual including the authors, and the leading journals where primary care research is presented are reviewed to check for possible nominations. The sponsors take no role in the selection procedure, and it is a tribute to Boots' reputation for integrity that almost all nominees accept their paper being submitted for the award. The award itself is associated both with an academic event (the annual Research Seminar of the RCGP), and with a formal dinner — where year on year the topic of conversation has been the value of encouraging and extending high calibre primary care research, and where the fruits of many such labours can be celebrated.

This year, 22 papers published in 2002 were given detailed consideration by the panel. They came from eight different journals, included authors from more than 20 different disciplines, and covered topics such as mobile phone texting to supporting young adult asthma sufferers, randomised controlled trials of service developments, and the cultural changes required to support clinical governance. The final decision was not easy, as there were many excellent papers; among which there is one deserving special mention — a single-authored article by a service GP, which shows that important research can still be done by non-academics in clinical settings.

The overall winner was an impeccably presented epidemiological study, authored by an international team whose UK base is in the Department of General Practice and Primary Care at St George's Hospital Medical School. Its lengthy title, 'Application of Framingham risk estimates to ethnic minorities in UK and implications for primary prevention of heart disease in general practice: a cross-sectional population-based study', reflects a complex and labour intensive study involving the recruitment and screening of 1577 patients aged 40 to 59 years from three different ethnic backgrounds. The authors say little of the challenges involved in securing this level of participation in a community sample, especially from some potentially 'hard to reach' groups, but this was one aspect that particularly impressed the panel. In this era of guideline-driven medicine, it is essential that our research reflects the diversity of UK population, and this team

The winners: L–R: Professor Pasquale Strazzullo, Dr Sally Kerry, Dr Pippa Oakeshott, and Francesco Cappuccio.

2

are also to be celebrated for their systematic attempt to do what befits all academics: that is, challenge assumptions — in this case, that the previous coronary heart disease risk estimates would hold for people from different genetic populations.

The key conclusions of the paper are that the Framingham risk estimates of CHD underestimate the risks of cerebrovascular disease in south Asians and Africans, and implies a need for different thresholds for intervention, also showing their increased overall risks if hypertension is undertreated. The paper therefore clearly shows the potential racism of assuming that 'one size fits all' in cardiovascular and cerebrovascular risk assessment. The question is original, the findings applicable, and the methods and analysis of high quality. In particular, the complex statistical data are appropriate to the questions asked, and concisely presented, with suitable textual guidance for the non-expert reader. The paper is intellectually heavyweight, one of the kind which makes MRCGP candidates groan, and certainly not one to flick through for entertainment value. The Panel were again impressed by the ability of the authors, who avoided patronising the readers by 'dumbing down' the details of the study while elucidating clear and concise messages for practice.

Those who return to this article because of its success in gaining the award may be surprised that the authors acknowledge many questions that this study does not answer. It is a sobering fact that even such an extensive study in an ongoing programme of work can only produce a very few robust conclusions for clinical care, and both government and research funders need to understand that work of this calibre is not cheap. While outputs from excellent primary care research teams are increasing across the UK, there has been a relative 'plateauing' in overall funding available for this kind of applied research. This could prevent such studies being replicated in different populations, reduce their ability to arrive at definitive practice guidelines, and thus 'widen inequalities in management of hypertension and prevention of cardiovascular disease'.[1]

In conclusion, the panel congratulates the authors on this excellent study, and the *BMJ*, on once again being the publisher of the Research Paper of the Year. Thanks are due to Boots for their continued support and sponsorship, and thanks to all those who helped with the nominations and the award. We also want to acknowledge the efforts of the whole primary care research community for their efforts: knowledge which is hard won, on which the progress of our discipline and the health of patients relies.

Amanda Howe

neville goodman

Spring

WE'RE in training. We're returning to a favourite haunt on the west coast of Scotland in a fortnight. It's 31 years since our first visit. We have stood at the top of every hill there bar two — and both involve a long trek in and a steep haul up. We need to loosen our limbs. The Mendips, Quantocks and Cotswolds don't have the height but in places they have the steepness, and we have to do our best with the material we've got. It's reminded us that there is no season to compare with the few weeks that cover late spring and early summer.

Topical issues and editorial whim may mean you read this column in late summer. Yes, there is the wonder of hazy sun over waving ripe harvests on rolling hills. Or in autumn: russet woodland dripping after a downpour. It may even be winter, and low bright sun on hoarfrost takes some beating. But spring-summer — late May in the south but more into early June farther north — never disappoints. Even if the weather is foul the countryside is beautiful because, colour in the hedgerows or not, green is beauty.

The human eye distinguishes more shades of green than of any other colour. Colour isn't real, of course. Where one colour of the rainbow shades into the next is an arbitrary distinction, and certainly the boundary between green and blue — the domain encroached upon by both colours, which we call turquoise — has led to many disagreements in our house. I've heard evolutionarily-based arguments that distinguishing greens is important for knowing what is good to eat. Well perhaps. But such arguments are rarely more than speculation because the experiment can't be run again, and who will be there long enough to observe?

Driving to work the other morning it was windy and unpleasant. But each tree, in the wind, partly wet and partly dry, sported half a dozen shades of green. Later in the year, they will dull; there won't be the contrasts. Summer is a more uniform season.

We'll return from Scotland, flushed with the triumph of those two last hills (or, beaten back by the weather, planning the next assault). We'll vow to walk each weekend but probably won't. Having an objective, and knowing it's the spring, are powerful forces.

You'll have to guess where our heaven is. The sun sets in the jaws of the loch at 10.25 pm on midsummer's day. We'll walk out after dinner and sit on a slab of Lewisian gneiss to watch it. And the NHS will be a world away.

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Neville Goodman had just promised not to mention Alan Milburn in his next three articles when, suddenly, Milburn dematerialised. 'Bad news for his family', quipped Nev

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And finally...

Lorraine Law who hasn't written anything for this issue of the *BJGP.* But as **Journal Manager** for the last five years nothing would have happened without her. She has re-designed the journal, manoeuvred us online, prepared the journal for electronic paper handling, and generally done the business. She moves onwards and upwards with our very best wishes.

jill thistlethwaite

Cleaning out my closet

WHY did you decide to study medicine? As a discriminating question to help choose between applicants for medical school, this certainly has its faults. The routine answer is, of course, to help people. But once embedded as an undergraduate the truth soon emerges: money, prestige, job security, and somewhere down the list, job satisfaction.

I decided, at the rather late age of 17, to try for medical school because I wanted to work abroad. At that time I had only been to France. It was an era when Mancunian estate kids were not introduced to skiing trips as toddlers, or taken on the grand tour as teenagers. While my father had reached Australia on an aircraft carrier at the end of the Second World War, my mother has never had a passport. I had some grandiose vision of working in the jungle and, yes, helping people get better. There was a certain amount of altruism involved but most of all I wanted to be somewhere else.

A wonderful elective in India reinforced the wanderlust; though I was naïve enough to think that a sixth-year English medical student was entangled in the same poverty trap as most of the people I met there.

So look at me now: I have worked in London, Buckinghamshire, Cornwall and Yorkshire. (I have travelled, but only for pleasure.) And a midlife crisis has made me realise that if I don't go now, I never will. At this age though, working abroad is no longer attractive without a full salary and pension package. I am also old enough to realise that most expatriate doctors do not make huge differences to the health of nations. They may accomplish the same one-to-one effect that they have back home, though communication is certainly a problem. The job satisfaction is mainly derived from exciting new experiences and the warm weather rather than the Mother Teresa effect.

I haven't got a job yet but I'm looking. However the impetus to move has awoken in me a desire to unclutter my life and 'clean out my closet', in the words of the infamous white rapper Eminem. What an amazing amount of flotsam you gather while living in the same house for 16 years; hoarding junk like we hold onto medical records, just in case there is a law suit or sudden need for mid-1980s copies of the *BMJ*. But even though I have the motivation to chuck it all out, throwing things away is a difficult business.

To start with there are books. Books I have read and will probably never open again but whose titles I like to see on my shelves. At least they can go to Oxfam, though only one or two at a time, as I desensitise myself slowly to their loss. As for medical books: when does such a thing become a historical artefact rather than an out-of-date text?

I have found things I thought lost forever (my original GMC registration certificate, since replaced) and photographs I wish I hadn't unearthed (did I really have such short hair?). There are certificates from half-marathons that I haven't looked at for over a decade, which suddenly become precious as proof that I could once run 13 miles in 90 minutes.

Then there are clothes. I read recently that we spend hundreds of pounds each year on garments we never wear. I have ample proof of that. But there are also items I haven't worn for a few years that I am certain I might possibly want to in a few more. I will stomp about once again in those high heels when the inflammation in my first metatarso-phalangeal joints settles down.

My husband has threatened that if and when we do move and it involves an aeroplane, we are only going to take the free 20 kg of luggage each.

Ask yourself … would you agree to that?