The Back Pages

viewpoint

Medical education — front page news in Papua New Guinea

'Having learnt little from good examples, I make use of bad ones, which offer me everyday lessons.' Montaigne *Essays*

Medical education, while the stuff of endless academic debate, is hardly the meat of the tabloids. Yet media interest in Papua New Guinea has focussed upon criticism of the present medical course — one devoted to problem based learning (PBL), which replaced the traditional model in our medical school in 2000. In an angry correspondence, critics of PBL have suggested that the doctors trained in the new tradition are worse trained and less competent than their peers across the world. More to the point, they are not as good doctors as those trained in 'the old dispensation' pre-2000.

There seems to be a great deal of opinion, but little evidence. It seems that medical education with its enthusiasts and detractors is a matter more for belief than for scientific inquiry. The *BMJ* in September 2002 tried to ask its readers to define 'a good doctor' and there was no real agreement despite passionate debate. If we are uncertain about the product of medical education it is difficult to be precise about 'how we best make doctors'.

Medical education has arrived. There are training courses, university departments, Master's degrees, journals of medical education ... all devoted to the subject. In the wake of all this enthusiasm has come change — the new syllabus has reduced teaching of anatomy and has taken on behavioural sciences, environmental science, ethics and law; the pre-clinical and clinical disciplines have been integrated and are taught side by side; there is an emphasis on lifelong learning and the new information age in extracting evidence from the internet; there is interactive computer teaching and learning programmes. It all seems broadly sensible, consistent and modern.

It is very difficult to get hard evidence, at the level of doctor performance, after receiving any particular model of medical education. Ten years after qualifying it is impossible to tell how or where a doctor was trained. In principle you would need to do a sort of Framingham study on doctors trained in different schools and follow performance over a lifetime. But by the time the evidence came in, it would have all changed anyway for medical educators are great innovators and changers.

People going into medical school in 2003 are among the most able in the country. The old gibe, 'people who cannot do maths do medicine', no longer applies. Competition is fierce and it seems likely that such gifted individuals would qualify almost regardless of how they were educated. The general public and the GMC have a say too; the doctor has to have a minimum competence as a physician. He or she has to be 'safe' or perhaps 'good enough' which may mean being at least as good as 50% of one's peers 90% of the time.

PBL was introduced in Papua New Guinea in 2000 across the whole 4 years of the School of Medicine (the student body numbers 200). The first, 'pure PBL graduates' complete in 2003. Other student cohorts had 1 or more years of the 'old curriculum' and the rest as PBL. They are sort of educational hybrids and seem none the worse. It has been a major effort and achievement in a country like this one — notoriously, 'the land of the unexpected', which is shorthand for 'there are more than the usual run of avoidable cock-ups'.

Is it possible to tell the difference between a PBL doctor and a conventional doctor 10 years after qualifying? It seems likely that it is those first emotional and frightening years after qualifying that have a greater effect upon the tyro practitioner.

Importantly, medical education should be enjoyable and fun. The analogy of lighting a fire for life, which needs constant fuel (new data) and oxygen (time and energy) and the dead ashes raked away, is a good one. The old model of filling the bucket with facts and a slow leakage for the rest of one's life was equating medicine with a craft rather than a growing science, but it still works for much of our work. The best teachers, whatever their methods, have been enthusiasts, actors, dreamers and poets who could occasionally inspire and always interest.

Debate about PBL rumbles on. The McMaster medical student I met once in Africa summed it all up for me. 'You can get a baby by IVF or by sexual intercourse and most people think the second a lot more fun!' PBL is more fun.

Peter Sims

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news

viewpoint 2

Can GPs and PALS be friends?

THE government is introducing a raft of new initiatives to increase patient and public involvement into the NHS in England (www.cppih.org). These include Patient Advice and Liaison Services (PALS), Patient and Public Involvement (PPI) Forums, and Independent Complaints and Advocacy Services (ICAS). All these are relatively new local services which together replace Community Health Councils (CHCs), but not the complaints departments and/or procedures which already exist in every NHS trust, primary care trust (PCT) and each general practice. The large number of new acronyms indicates the complexity of the new arrangements.

It is difficult to fault the broad intentions behind this strategy, which is designed both to inform improvements to services and customer care, and to address the 'democratic deficit' of the NHS (the largest public sector organisation in the country is not locally accountable). One may, however, wonder about the motivations for such a strategy.[1] Is this an attempt to turn patients into consumers, and health care into a market? Or is it an attempt to legitimise healthcare rationing by making members of the public share the responsibility?

The complexity of these arrangements has led to a great deal of confusion and misunderstandings about roles. Worryingly, the government shared such misunderstandings at the outset, when it changed the name of PALS from 'Patient *Advocacy* and Liaison Service' to 'Patient *Advice* and Liaison Service'. The change was made because it was pointed out during consultation that NHS employees could not offer independent advocacy support to those complaining against their own organisation.

Every NHS Trust and PCT should by now have a PALS, although some trusts are struggling to make funding available for an adequate level of service. The purpose of PALS is to:

- offer information and advice about health and other services,
- help patients resolve concerns and dissatisfactions quickly,
- feed back to senior managers their learning about ways in which trust services fail patients, in order to promote culture change.

With regard to the second of these, it is intended that PALS should supplement complaints procedures, which may be too formal and unwieldy to meet the needs of dissatisfied and non-litigious patients. It is of course true that GPs typically handle their own complaints and try to resolve them informally, while some complaints departments and in the past CHCs have attempted to do likewise. However, such approaches are not always successful, whoever is involved, and it is useful to be able to call on PALS as intermediate brokers. PALS are not intended as a way of avoiding complaints procedures where patients wish to use these. Complaints are generally handled by a separate department, and advocacy services, such as ICAS, should support patients who do complain formally, not PALS.

Of course, concerns about GPs themselves may be raised with PALS and this can be a point of tension for GPs and PALS. However, it should be remembered that some patients previously took complaints about GPs directly to CHCs. But then, CHCs were independent, whereas PALS are part of the PCTs within which GPs work. Not surprisingly, PALS has been regarded as yet another ingredient in the ever-increasing mixture of PCT surveillance and interference to which GPs are subject.

Furthermore, PALS are also tasked with feeding back to trust managers, so that the collective experience of patients can be used to bring about improvements in service delivery. This is likely to be more useful in changing the practice of directly employed PCT staff than that of independent contractors, such as GPs and dentists, and their teams.

So does PALS have anything positive to offer GPs? Certainly, from research currently being undertaken at City University,[2] we know of examples where GPs have felt very supported by PALS officers, who have been even-handed and constructive in resolving patient concerns. GPs have been able to turn to PALS officers for advice on how to handle particular situations, such as help in drafting a letter responding to a complex complaint. It is also evident that PALS have been able to make significant improvements to services. For example, one PALS received repeated complaints about a PCT department that appeared never to answer the phone. A PALS officer, who spent a morning in the department, discovered the limitations of the telephone system in use, and discussed

References
1. Meyer J. *Lay participation in care in a hospital setting.* Portsmouth: Nursing Praxis International, 2001.
2. Abbott S, Bentley J, Lanceley A, Meyer J. The early lives and times of London PALS. *British Journal of Health Care Management* 2003; **9(1):** 18-20.

possible solutions with staff. Once fully aware of the problem, the department used PALS' support to apply successfully for funds for a new system. Although GPs often try to act on behalf of their patients in correcting process faults such as this, they do not have the flexibility to take the approach adopted by this PALS officer. It can also be of benefit that PALS officers are fellow employees of the PCT: staff may feel less defensive than if they were discussing problems with outsiders.

It is true that these examples are taken from a well-established PALS service, which is generously staffed and led by a complaints manager who for years has cultivated good relationships with GPs. Other PALS are much newer, and often have only one or two staff, who struggle to create and sustain good relationships with so many others: the PCT and its departments, the GPs and other independent contractors, such as dentists and pharmacists, and community and patient groups.

In any case, as local PPI Forums and ICAS are set up in the latter part of 2003, the roles of PPI organisations will become more confusing. Patients will inevitably approach the most convenient source of help, particularly if local ICAS have a presence in the 'high street', as CHCs did. Thus, the new arrangements are likely to be frustrating for patients who have to be referred elsewhere, for PALS staff who will have to clarify the arrangements to patients, and for GPs and their teams who will need to relate to a multiplicity of staff in these new and varied organisations.

GPs and other primary care staff who are committed to responding positively to patient concerns will of course find a way of making the new arrangements work. And we have found plenty of evidence that PALS officers themselves, while fully aware of the size of the challenge, are enthusiastically finding ways of working effectively. In time, custom and practice will solve some of the teething problems, or find 'work-arounds'. But it is a pity that the new initiatives currently appear to be more a set of problems to tackle than a set of arrangements to support and facilitate.

Stephen Abbott
Jane Bentley
Anne Lanceley
Julienne Meyer

flora medica theophrastus bombastus

From the journals, August 2003

***New Eng J Med* Vol 349**
523 Hormone replacement therapy (HRT) is the dominant theme this month, beginning here with the final report of the Women's Health Initiative (WHI), a randomised controlled trial of combined HRT in women aged 50–79 years. It was terminated prematurely when it showed an increase in cardiovascular mortality and morbidity. However, a study which examined coronary atheroma progression with and without HRT over 3.3 years found no difference (page 535), and HRT does not appear to increase risk of heart failure (*J Women's Health* **12:** 341). But it certainly increases the risk of breast cancer, as shown by the observational Million Women Study (*Lancet* **362:** 419). Any benefit to bone is quickly lost, but there may be a place for ultra-low dose continuous 17ß-oestradiol in some women (*JAMA* **290:** 1042). Venous thromboembolism (VTE) is a risk with all oral HRT but this may not be true of transdermal oestrogen (*Lancet* **362:** 428).
570 The ability of adult stem cells to differentiate into various tissues, and so repair damaged organs, opens up magical therapeutic vistas. Here is a good clear summary of them: for discussion of myocardial repair using stem cells, go to the *Lancet* editorial, (**362:** 675).
733 Another study showing that the best treatment for myocardial infarction is immediate cardiac catheterisation and reperfusion.
875 A clinical discussion of bulimia nervosa, stating that both cognitive behavioural therapy and SSRI antidepressants have a good evidence base.

***Lancet* Vol 362**
345 End-of-life decision making is needed in about two-thirds of deaths in the developed world, and usually involves both the patient and relatives. The Ethicus study reported in *JAMA (***290:** 790) explores the influence of religious affiliation on such decisions in intensive care units. In the Netherlands, demand for physician-assisted death has levelled off (page 391).
383 A good seminar on coeliac disease, though it is even commoner than the 1 in 266 quoted here. A Cambridge study using endomysial antibody revealed undetected gluten allergy in 1.2% of adults (*Gut* **52:** 90). A study in *Ann Intern Med* (**163:** 1566) also showed that it is associated with higher all-cause mortality, but lower cardiovascular risk.
523 Another theme this month is VTE. This prospective study shows that 'thombophilia screening' is a waste of time: the likelihood of recurrence after post-surgical VTE is zero over 2 years, whereas following spontaneous VTE it is 19%. For the latter group, D-dimer measurement after stopping warfarin can identify a group who are virtually risk-free (*JAMA* **209:** 1071). A study in *New Eng J Med* (**349:** 631) confirms that the international normalised ratio must be kept between 2 and 3, and the editorial on this (**349:** 675) contains further useful discussion of VTE.
593 Annual spiral CT in heavy smokers catches 95% of tumours at a resectable stage: those of 5 mm and under do not progress significantly in 12 months.
604 Depression is known to be a serious prognostic marker following myocardial infarction, and in heart failure: this study shows the same following coronary bypass surgery.
717 The big review of dyslipidaemia you have been waiting for.

***JAMA* Vol 290**
781 Human papilloma vaccine may soon be with us: this paper looks at using it cost-effectively to prevent cervical cancer.
891 Contrary to the assertion of cynics, 90% of people who get cardiovascular disease have at least one commonly recognised risk factor: so much so that a search for other risk factors is probably pointless (page 932).
921 A review of studies paid for by pharmaceutical companies showing they are likely to report data which are favourable to the company's product.
1029 Black chocolate may be good for your systolic blood pressure.
1033 Two US studies showing that sertraline is safe and effective for major depression from ages 6–17 years.
1049 Another Framingham Risk Score, this time for death or stroke following onset of atrial fibrillation. Simple conventional risk factors prove their worth again.

Other Journals:
Carpal tunnel syndrome is a painful and disabling condition often involving interminable waits for investigation and surgery. *Neurology* (**61:** 389) reports that ultrasonography is probably more useful than electrophysiology, and a study in the *J Bone Joint Surg* (**85-B:** 869) showed that accepting the GP's diagnosis and giving patients direct access to surgery works.
'All I want you to do is swallow this wireless': no joke, but the very latest in small bowel imaging (*Gut* **52:**1090). The Chinese, famed for their dietary versatility, are enthusiastic wireless-eaters — see *Chinese Journal of Digestive Diseases* (**4:** 89).

Plant of the Month: ***Aralia elata***
In late summer, it carried plumes of milky flower: now enjoy the oranges and crimsons of its huge pinnate leaves before they fall.

Reflections on compiling a personal development plan

An angry woman's Personal Development Plan

I sit in my conservatory, wine in hand, the cacophony of light sabres from *The Empire Strikes back* in the background.

The task? To put together a 'PDP' ready for my appraisal interview in 4 days' time. As if I had nothing better to do on a Sunday afternoon.

For some months now a jumbled collection of papers have resided in a folder quaintly labelled 'Karen's PDP'. But what does PDP stand for? I had to double-check. Yes, it seems to be Personal Development Plan, so lets proceed ...

I have the PDP delegate workbook to assist me. I have a CD ROM but not the skills to set it up. I have a colleague's PDP already scrutinized by the postgraduate tutor to peruse. And I have just returned from a 2–day retreat in medical humanities.

Thus, it is with a great feeling of satisfaction and smugness that I now place the majority of the aforesaid bits of paper in the recycling bin. PDPs, PUNS, DENS, Portfolios, the lot of them. I review the PDP of my colleague Dr de Quincey, an experienced, articulate, caring doctor. Four pages of reflective writing precede his 'PDP workbook document'. Here, he expresses feelings close to his heart about the state of our profession before he prostitutes himself to complete the little boxes about 'Himps' and 'Audit' and 'What do I do well?'. To think that the profession has asked a man of his capabilities to demean himself in such a way by answering these questions and called it personal development, in order to fulfil an externally dreamt up requirement which is the equivalent of throwing a slave to the lions, sticks in my throat like a piece of meat ready to be regurgitated.

And about to be regurgitated it is, because I will not do it. I will, and have, completed the appraisal document, which was thought-provoking and relevant. I will also collect together in a portfolio, evidence of measurable activities in my professional life, which contribute to its development.

But I will not attribute any of these to a heading of personal development. It strikes me that whoever dreams up these terms do not understand the meaning of the words they use. *Personal* — adjective or noun, meaning 'one's own, individual' and *development* — noun, meaning 'gradual unfolding, growth.

So personal development means surely the gradual unfolding of one's own self? What has 'Himp' or ' Audit' got to do with this process I may ask? My eloquent colleague speaks of our work 'emotionally testing us'. Has the profession ever in the 19 years I have been a doctor offered me resources to cope with these demands? Is their idea of this the Counselling Service for Sick Doctors, the number of which lies embarrassingly hidden on the inside cover of the *BMJ*?

So, to need counselling you must be 'sick'. Really what this says is that you somehow let an emotional missile from your work penetrate the armour plating built up painstakingly at medical school.

I believe as a doctor that I have a responsibility to my patients in several areas. Many of these are covered in the appraisal document — probity, health — and I look forward to having them further explored in my appraisal interview. I would even relish some form of assessment of my clinical competence that at present is not covered!

But to ask me what I think I am good at, and not good at, annoys me, and to tart the whole process up and call it personal development enrages me.

Personal development is concerned with the growth of the individual. As doctors we need resources to cope with the dilemmas and emotional traumas that our profession brings to us on a day-to-day basis. I am fortunate to have discovered medical humanities. For me this is a resource and my PDP this year is encompassed in my recent retreat. Of course, personal development happens silently, day after day, but since my last retreat 18 months ago it was evident some unfolding had occurred.

My colleague finishes his reflections by saying, 'the fact that I should prescribe fact-based learning to myself at best misses the point'. Misses the point! Unfortunately, I do not feel able to be so forgiving. It's about as far away from the point as the Virgin Mary was from a brothel. By all means, help me establish my learning needs, scrutinize my practice, test my abilities, but do not speak to me of personal development until you understand its meaning and its vital contribution to my role as 'a good doctor'. My retreat clarified for me that I have personally developed in the 18 months since I last took stock. It has no doubt benefited me, my family and my patients. But it is not to be found in so-called 'Personal Development Workbooks'. It's in my heart and it's a good job that my patients know where to look for it, as the profession seemingly does not.

Dr de Quincey's reply

Karen, you're invoking arguments that in:

- Referring to 'the meaning' (here of personal development) as something to which you have privileged access over all-those-idiots-who-try-to-lord-it-over-us, at best come across as petulant, and at worst get lost in the invective.

- Thus appropriating 'the meaning', alienates you from what seems to me a central tenet, nay *raison d'etre* of medical humanities — namely that yours is just another story among innumerable other takes on the world.

For me, we undergo personal development by constantly writing and re-writing our autobiographies, re-describing ourselves and our relation to the world. This quite simply is someone who is having a go at getting their head round themselves, insight if you will, so that life up to this moment is at least an attempt at a successful summation of all which led up to this moment.

The poor buggers trying to see the profession accountable, likewise have another take on the world. As managers, they have to approach something from their end, and you from yours; what you cannot do is claim *a priori* high ground *because* of being a coalface GP.

How much better to sound like someone who hears the other stories and makes them part of the next version of yourself; you'd come across better to acknowledge that you've become a different person as a result, not just of medical humanities, but of the very act of getting vexed over PDP; instead it sounds like a retreat from the latter into the former.

So the only way you'll win out over the hijackers of personal development is by your *style*, by the way you come across after having listened to what they're trying to do, and being as fully as possible in touch with the character you've become (in the sort of world where the powers that be might expect you to do a PDP).

This isn't an argument for superficiality — it's only saying that the stuff we attend to is finally subsumed under the way we attend to it. We're presumably worried about pomposity in doctors because we think it doesn't work very well (clouds bipartisan relationships and impairs decision-making), as well as the more fuzzy stuff about not liking its smell.

If you can tell me that the anger I've seen from you about such pomposity is where you want to end up about it, then maybe you're just an angry cow. In which case, if I can suggest that angry cows don't work very well, then you might just as well be pompous.

If it is a valid emotion on the way to telling me how you're going to exist as a doctor-character who is different and so makes the world different by existing, then get on and tell me/live it.

More immediately, if you sound in your writing like someone who could not assimilate, or felt they had *a priori* trumping over this argument, then how do I know there isn't at least one other sort of character out there for whom you might do the same thing behind the consulting room door — close down the options and retreat. I certainly can't share the terrifying certainty of your last sentence that your patients will know where to look for the other side of you.

Dr O'Reilly tries again …

Let me try and put it another way I'm not aggressive or pompous all of the time. I'm bits of things on different days and in different situations.

What I think I have learnt is to recognize which bits are which, how they got there, why they come out to play and not to panic when they do.

My anger stems from resentment and hurt that in years gone by the profession that is supposed to help people didn't help me. Day after day I'd attend to the physical and emotional needs of my patients, while all the time my own emotional needs were neglected. I felt as if my medical school training had been designed to rob me of keeping in touch with my emotional world. This was a side of my role as a doctor that wasn't mandatory and could get in the way. When someone in the course of my general practice training tried to tap into the emotional torrent it was done in a clumsy and inappropriate way and left most of those who experienced it even more resentful.

With time and maturity, or whatever, I can look back and understand these things, but at the time it was really quite unpleasant. As time has gone by I have found ways to move forward emotionally, albeit sometimes in a rather chaotic way. I feel I am making progress and it's how I feel that matters to me and, indirectly, to those that know me.

Let me give you a specific example. When I was a little girl I wanted to be an actress but my parents laughed at me. Well now I am an actress of sorts aren't I? And I love my job. I don't feel burnt out or stressed. I feel challenged and satisfied.

Part of my job is the science bit. I need to know facts, know how to use them, know how to 'do' stuff like drips and minor operations. And I'm glad the profession is trying to bring in some way of monitoring this. That is reassuring.

But this part is probably akin to an actress learning her lines. Anyone can learn lines but what makes an actress great? Her delivery? Her style? Well, it's not a very measurable entity, is it, but for me I see this bit being the person that I am and this is where my 'personal development' comes in.

Another example. My father died when I was 20 years old. Being an only child and a 'daddy's girl' this was, as you would expect, a pretty devastating experience. Two days after his funeral I was back at medical school studying with the Second MB only a few weeks away. I sailed through. 'Didn't she cope fantastically?'. Never having grieved properly, the pain of my father's death lingered on year after year. Whenever I would attend a terminally ill patient my emotions would bubble out. It wasn't unusual for me to be more visibly upset than the relatives.

But this was my pain. I was crying for myself. Eighteen months ago on the medical humanities short course we were prompted to write a poem about something important to us. I produced a short poem to my dad. I sobbed all the way through writing it and all the way through reading it out to the group.

But since then I can think of my dad fondly, feel comfortable with my pain at losing him and can now approach patients as they approach death with a feeling of sadness without letting my own intense pain get in the way. This to me, rightly or wrongly, constitutes 'personal development'.

I'm not suggesting that we all go round sobbing, writing poetry. Only, for me, that worked. The important thing is that we recognize that as doctors there is a part of what we do that is part of who we are and where we are on our own emotional journey.

And this intangible bit is what makes an actress great or maybe a doctor 'good'. Yes I have angry bits. I have vulnerable bits. I have some low self-esteem. I have some need to be needed and some fear of needing someone.

But overall I quite like the funny mixed-upness that constitutes 'me'. I no longer feel the need to be 'totally sorted'. I've learnt, I think, to just live my life as it is and relish all the things that come my way. Like a child rummaging through an old box of toys. I can enjoy the experience without fretting that the toys lay strewn across the attic floor are not in neat, tidy piles.

I don't write to be right. Or better. Or revered. I write to feel. For me reflective writing is a way of expressing emotions, which at the time of the consultation may be inappropriate or impossible to visit, but which nonetheless cannot be ignored. Not that is if the doctor and the patient are to get the best out of the consultation process, which at the end of the day is at the heart of what we do. It is not rocket science. It is not even new.

But isn't it about time the profession came out of the closet and recognised this sufficiently to put in place some resources so that we could actually consider having a 'PDP' in the true sense of the word?

Karen O'Reilly
Matt de Quincey

Postcards 4 ... The tangled net

WORKING in the NHS sometimes feels like being caught in a tangled net. Read codes spread like barnacles across the consultation, defensive medicine scleroses decision-making and we seem more concerned with the disease than the person who has it. Outside the consulting room work often reduces to a frenetic round of targets, meetings, institutional fads, crazy deadlines and a chronic mismatch between aspirations and funding.

Look back 10 years ago and it is clear that practice is changing rapidly — but in a manner that feels enormously frustrating. This sense of walking through treacle can seem like failure — personal, practice, political or institutional. In fact it has very little to do with health services per se and everything to do with the wider governance of the public sector.

Twenty years ago all services were delivered as hierarchical bureaucracies — we just referred orthopaedic problems to the orthopods most of whom we knew personally because they and we had worked in the same silo institutions for years. These inflexible and paternalistic bureaucracies then gave way to markets. We attempted to regulate care via the price mechanism and fund-holders made hay with ‘buy one get one free’ offers on hip replacements.

Today, amidst the archaeological rubble of previous systems, services are being delivered through multiple, fragmented networks. When referring an orthopaedic problem I am now faced with an ever-greater multiplicity of services and ever more people across the network that want to influence that decision. We suffer our very own version of attention deficit disorder as numerous issues jostle for attention. The guidelines, the new single point of access, the patient’s own researches on the net, the latest GPwSI service that the primary care trust (PCT) is starting, the need to code the encounter accurately — which is going to get headspace?

The move from bureaucracies to networks is happening right across society and is driven by what has been called the hollowing out of the state. Recognising that central control cannot deliver the flexible, personal services that the public now demands; governments have devolved control and budgets downwards. At the same time transnational pressures — EU dictates, globalisation, the power of multinationals to move investment around — force governments to cede power upwards and outwards. The end result is that the state becomes hollowed out: government is called on to deliver more while its ability to directly control that delivery is progressively whittled away.

Faced with this unnerving vacuum, governments across the world have increased budgetary straightjackets and imposed output-based targets. At the same time they declare — and sincerely believe — that the balance of power has moved decisively to the front line.

All this reinforces regulation. Targets, protocols, the judiciary, instant media communication of high profile failure, multiple inter-dependencies between programmes and agencies — all inexorably lead to more regulation. CHI, NICE, NCCA and the rest proliferate to fill the gap between fragmenting central control and increased public visibility.

On the front line this can feel like chaos. In reality a new form of order based on networks not hierarchies is emerging. In the old days — 10 years ago — the NHS was largely a centralised hierarchy where each practice related to a singe hospital and every patient was registered with a single practice. Now network-driven policies are rapidly emerging. Enhanced services will mean a rapid expansion of inter-practice service provision. By 2005 patients will be offered a range of hospitals to choose from. And John Reid’s recent suggestion that patients should be able to register with a PCT means patients may be able to use several practices for different problems. The one-to-many hub and spoke model of the old NHS is being transformed into the tangled web of the many-to-many distributed network.

Happily our formal understanding of networks has advanced rapidly recently. Insights from research on the internet help predict what the new ‘networked’ NHS may be like.

Firstly, horizontal relationships between nodes (be they people or organisations) become much more important than vertical command. For practices this means that relationships with neighbouring practices become dominant — think of locality groups, local commissioning, sharing enhanced services. For professionals it means that teams are becoming essential to the delivery of care — understanding what the practice nurse is doing and how that relates to the work of the PRIMIS facilitator has just become key to meeting your quality outcomes. For patients it means becoming both empowered — for example via web-based resources — and bewildered as super-specialisation is delivered across fragmented services.

Secondly, the behaviour of networks is controlled by flow through the network —

be it of patients or money — rather than its structure. No surprise therefore to see that the policy offering choice to patients goes hand in hand with one to reform financial flows and set national tariffs for elective procedures.

Finally the number of connections across a distributed network does not rise linearly. Increasing the number of organisations dealing with an issue from four to six means the possible inter-relationships between organisations rises from 16 to 36. Hence endless meetings and exponential E-mails.

Networks and the hollow state are two of the interlocking forces changing the NHS. Together they mean that we can no longer be lords of our own domain, surveying the consulting room and all it holds. Instead we are nodes in the net — the patient pulls this way, the PCT that, guidelines tighten the web, the churn of staff can loosen it.

In this complex, networked world Sod and Murphy work their usual laws and the sour law of unintended consequences can and does befall us all. But typically this is not because we are stupid, lazy, ill-intentioned or under-resourced. Unintended consequences are inevitable because new knowledge is being added to the world at an ever-faster rate. And new knowledge does not increase control of the social world — it alters that world and sets it off in new and unpredictable directions. Networks actually reduce the risk of all this new knowledge for even if several nodes cease to work the network still functions. Being a node in a net is actually safer than being a lynchpin in a hierarchy — it just does not feel that way. It feels as though we are loosing autonomy.

Looked at differently, general practice is well placed to deal with a world built on networks. Structurally we already are a network of semi-autonomous units linked through a web of relationships.

Even more important we are the 'Googles' of our communities with thousands of connections stretching across every street and strata of our localities. In network terms practices are much more deeply rooted, and by much more meaningful transactions, than shops, post offices or even schools. This connectedness is likely to be a huge asset as we find ourselves delivering complex care in an ageing society made up of fragmented communities.

For years general practice has been the sleeping giant of community development — by and large we have been in our communities, but not of them. In the coming decade making the most of the roots that intimately connect every general practice to its network of carers, families and organisations will be just as important as staying abreast of the latest developments in genomics.

Paul Hodgkin

Sod and Murphy get networking

'A mostly sunny day, to some, can look a lot like partly grey' said Eeyore.[1]

Eeyore was a past master at expecting the worst. Yet despite what we see on the news not everything always turns out for the worst and not every unintended consequence is a disaster. Viagra® has been a blessing for the Black Rhino with numbers soaring as the aphrodisiac market finally got turned on to evidence-based interventions. Limited access to computers in primary school has meant that poetry is booming among 8-10-year-olds as literacy lessons use poems to teach meaning and interpretation and so avoid the tedious chore of text entry.

My sister has a parlour game of asking what things have got unequivocally better over the last 20 years, and can produce a list that is cheerfully long — mobile phones, British food, power tools, computer literacy, the number of books in print, the variety of butterflies, the quality of British beaches, most museums and art galleries. And for health we could add the fall in coronary heart disease, road safety deaths, and the quality of most practice buildings.

Such Pollyanna-ish optimism is important because in a networked world improvements are often dispersed and difficult to see. Left to their own devices the feedback loops of the news media know they will garner more attention by concentrating on gore and than on success.

Of course Sod and Murphy have not completely morphed into Mr Pangloss. But networks by their nature are more dispersed, trickier to track, than hierarchies. Perhaps things are not quite as bad as they sometime seem.

1. Marshall H. *Lessons from the Hundred-Acre Wood.* New York: Disney Press, 1999.

essay

Samples from *Secrets from the Black Bag*

Two samples from *Secrets from the Black Bag*, accounts of rural general practice collected by Susan Woldenberg Butler.

Secrets from the Black Bag is arranged around the theme of home-visits. Eleven separate characters, including two doctors' wives, tell 65 interconnected stories, which cover many situations and experiences and express a wide range of age, viewpoints, high expression and downright folly.

Based on personal interviews, the stories have been heavily fictionalised. The GPs interviewed range from 40–80 years of age.

Some are refugees from Britain's NHS. Others are adventurers and idealists. The stories span 80 years and countries as diverse as Nigeria, Pakistan, New Zealand, the Falkland Islands, Tanganyika, England, Australia and Scotland, as well as the high seas. Some of the stories have been published in Australia; some are with two journals in the USA.

When an old-country laird plonks down a bottle of double-malt whiskey and, fire blazing and smell of roasting lamb and rosemary in the air, reminisces about a feral family he visited, well …

Susan Woldenberg Butler

Mrs McMurtry's dose

'Is this penicillin?' She wasn't stupid. 'Is it because my husband's given me a dose?' asked the well-dressed woman across the desk.

I'll never forget that day. My answers determined the subsequent course of my medical career. It hadn't occurred to me that I would confront an ethical dilemma on my very first assignment with a distinguished gentleman of the old school — the very old school. Patients don't walk in with signs around their necks saying, *Here's a good one for you, doctor. See if you can sort it out in 6 minutes*.

I was feeling particularly contented, for which I make no excuses other than that I was as green as the grass outside. And I was off guard, a fatal addition to inexperience and self-satisfaction in a medical setting. Humming jauntily, I peeked into the waiting room and saw four women. A dark lady in designer knock-offs turned the page of an architectural journal. A sweet motherly–type knitted automatically while talking to a female with aggressively grey hair and a grimace. A blond, middle-aged lady in cream silk read a popular feminist tome.

'Mrs' — I looked down at the file— 'Mrs McMurtry?' I looked hopefully at the maternal knitter, who glanced over at me and smiled.

The silk lady closed her book with a thump and stood up. 'Coming, doctor,' she said.

Maybe she wanted sleeping pills or to renew a prescription. Something non-invasive, I prayed, intimidated by all that elegance. Then I saw a message I'd missed in my haste, a note from the principal attached to the file. *See me immediately*, I read as I followed her down the corridor to the consulting room. After shepherding the lady to a chair opposite the desk, I excused myself and scurried down the hall.

I wasn't humming when I sat down across from my patient a few minutes later.

'Sorry for the interruption, Mrs McMurtry.' 'That's quite all right, doctor,' she said pleasantly, adding, 'This is the third consecutive day I've come.'

'Yes,' I replied, looking at the notes.

Mr McMurtry, a local politician, had brought his wife a little souvenir from a business trip, of gonococci. At least he had the decency to arrange for her to be treated, but he didn't want her to know why. We gave penicillin then as a single daily injection of long-acting suspension, something like 100 000 or 200 000 units, over a 5– or 7–day period. We gave it in the buttock, because it was bulky and painful.

'Could you strip down to your undies and hop up on the table? On your tummy, please.'

She looked at me for a long moment, then fired off those two fatal questions: 'Is this penicillin you're giving me? And is it because my husband's given me a dose?'

I was an honest chap. She was a patient with a right to know the truth, no matter what my principal said. After all, I had graduated from medical school. I knew something. I wasn't prepared to compromise my beliefs, no matter who issued the commandment.

'Yes, and yes,' I answered earnestly.

All hell broke loose. I never truly understood the meaning of 'to gather oneself up' until that moment. Mrs McMurtry's posture straightened. Her demeanour lost not an ounce of its composure. Her remoteness increased. Heightened facial pallor gave the only indication of the true effect of my words.

'Thank you for your honesty, doctor,' she replied icily.

I prepared the syringes as she slid onto the table.

Poor woman, having to endure such an unpleasant procedure. She submitted with better grace than I could have summoned. She uttered not a word of reproach, nary a whimper, during the indignity of being jabbed in the buttocks by a very junior GP wielding syringe after syringe, in an ordeal required by no action of her own.

'Thank you for your honesty, doctor,' she repeated. The quiet way she closed the door as she left did not presage my principal's thundering wrath.

'You did what?!' he screamed after I'd trotted down to see him.

'I, um ...' I faltered, the strong staff of truth temporarily wrenched from my quivering knees.

'Go on, explain yourself, if you can,' he spluttered.

I marshalled my forces and squeaked, 'It was the truth.'

'The truth!' he boomed. 'The truth!' I was petrified. 'You have ruined a marriage and lost the practice not one valuable patient but an entire family — not to mention the unhappiness your honesty' — he spat the word — 'will bring to all concerned, including yourself.'

I thought about my new wife and our idealistic promises to each other. 'Surely telling the truth cannot be such a hideous thing,' I replied resentfully.

This was before the days of the women's liberation movement. Concepts like truth-telling belong to a later era. At that time, medical ethics as we understand it did not exist in our intensely paternalist profession. The doctor was a god. Patients didn't question his — usually his — decisions and actions, so Mrs McMurtry's inquiries were unexpected and unsettling. I blurted out the truth without thinking. And if I had stopped to reflect?

'You have destroyed that marriage,' he repeated.

'Why didn't you see her yourself, then?'

'Because, dear sir,' he replied slowly, 'I thought your level of ability sufficiently developed to conduct such a session, an opinion unfortunately not validated.'

I hung my head. Telling the truth now seemed like a selfish act.

'You will be informed at the end of the day if your further services are required. I rather doubt it.'

A much-deflated locum saw a few more patients. The afternoon wore on. I had just finished writing a script when the phone rang. 'This is it,' I thought glumly. 'On the job a day and a half and already I've ruined the lives of two adults and God knows how many children. Multiply that over a career.'

The telephone's insistence interrupted my calculations. 'Yes?' I said.

I recognised the responding grunt. At least, after today I would never see my principal again, to my eternal relief and certainly his.

'I have decided to keep you on due to prior commitments to my family, commitments that I would break if I could. Unfortunately I have exhausted my store of spousal good will, although why I am explaining this to you I do not know.'

I breathed a silent sigh of relief.

'Please,' he said, 'I beg of you, do not make any more heroic decisions. Just refer patients to me. I will be back in exactly 12 days. If there is an emergency or if you have any problems whatsoever, even small ones, please, please, consult my good colleague down the road. The receptionist knows how to reach him, and I have been on the phone with him this afternoon.'

I detected a note of desperation in his voice. 'You put me in this position,' I replied, with no good humour.

'An error of judgment for which I shall pay for the rest of my days. This is a small place, you know.'

How should I have handled Mrs McMurtry's questions? I replay a variation of my response in my head, with the benefit of many years' experience. I should have called in both husband and wife and sat them down next to one another, with myself nearby, not across the desk, my knees almost touching theirs. I should have said to Mr McMurtry, 'If you want to save your marriage, you must confess to your wife and beg her forgiveness.' I should have taken Mrs McMurtry's hand and told her that everyone makes mistakes. From there, my own good sense and experience would have guided me.

By avoiding the truth, she might have steered her marriage to calm waters, despite being mated to a cigar-smoking, loud-mouthed, gonorrhoea-ridden bully. The principal knew about her floundering marriage. He had the greater knowledge and experience.

On the other hand, my principal and Mr McMurtry were golfing partners. They colluded to keep the politician's wife in the dark, when she had every right to know what ailed her. That despotic attitude still sets me off.

Mrs McMurtry taught me my first lesson in medical ethics. To this day, the poor woman visits me whenever the option of telling the brutal truth to a patient confronts me. I was never unfortunate enough to employ an inexperienced locum with a different philosophy of practice who was presented with a truth-telling dilemma, thank God.

A lonely death in the middle of the night

It started as a typical morning at the surgery until the receptionist put through a call. 'Can you go out to the O'Connor place, doc?' asked Lance Smith, a local policeman. 'A child has died.' 'Sure,' I said.

I hate it when children die, and I hate it more when the authorities call me in to pick up the pieces. My partner was stitching up a chainsaw accident, so I had to go. I got directions, since I didn't know the place. Had never heard of it, which was unusual. I thought I'd found every corner of the countryside.

'Another thing, doc. Better take the four-wheel-drive.' Warning bells should have rung, but they didn't.

The place was up the back of nowhere. Even the people who had farms nearby didn't know about it. I drove down a rough, rutted, rarely used road to a real humpy-looking place, thrown together from planky-looking wood. It looked roughly made and totally incomplete. No-one had painted it. In the yard sat one old car that went and another a fraction worse that didn't.

The door was opened by a man I knew by reputation. Tattoos covered every visible surface of his body. Behind him cowered a pushed-around woman with stringy blonde hair.

'Where's the child?' I asked.

They stood aside to let me in and pointed to a bundle on a makeshift bed in a dark corner. Two older children sat nearby, playing with a baby. There's always a baby to consummate the union.

'He had asthma,' the stepfather said authoritatively. The old scenario. We see it so often. These people didn't believe in doctors. They of course knew everything and doctors knew nothing. 'We know all about it. We treated it.' So often it's the stepfathers who kill these children.

'What happened?' I asked.

The previous night, they had given the poor little fellow some candle vapours to sniff and gone to bed, presumably drunk and stoned, if my nose was correct. They left him, with a candle, sitting by the fire.

The poor lad had obviously had bad pneumonia, with half his chest full of pus. He pulled a blanket over him and died. One jab of penicillin would have given the little bloke a good chance of living.

This poor child died a lonely death in the middle of the night in a bloody hovel. It was just so pitiful. This dead little kid was only 5 years old, and about the size of my 2-year-old. That he died alone bothered me, without even the comfort of a toy animal. With his last bit of strength, he dragged his filthy little blanket across the floor and crawled into bed to die alone. When people die, they need the basics of companionship and love.

They killed that child. It would not occur to these people that they would be at all responsible. I made four calls to child welfare, who never followed it up. Later I got distressed phone calls from the family of the real father, but what could I say?

That was one of the few times I haven't been able to bounce back to work. I went home and had a cup of tea. I still think about it.

Les Troyens

Sir Colin Davies, London Symphony Orchestra and Chorus
The Proms, Royal Albert Hall, London, 25 August 2003

How many times have I said: 'I must go to the Proms some day'? Don't ask. London is a long way from Newcastle and in any case we have lots of culture up here don't we? Not if reports that we are becoming known as the 'Faliraki of the North' are to be believed. So, the Editor's offer of a press ticket to hear Sir Colin Davis conduct Berlioz's Les Troyens in exchange for a review was most welcome.

This was the great Bank Holiday Monday extravaganza: La Prise de Troie (Acts 1 and 2) at 3 p.m. and Les Troyens à Carthage (Acts 3 to 5) at 7 p.m., with enough time in between to down a bottle of wine with some food. Excellent. Except that it being August Bank Holiday weekend, lots of people wanted to come to London for the Notting Hill Carnival, so it was a sensible time for Railtrack to close half the main lines in the country. But we won't dwell on that or on GNER, except to say that their service stinks and so do their trains if you have to stand for 5 hours propped up against the toilet door. But being British, we put up with it (although I did think it was pushing it a bit for a ticket collector to insinuate that we should be thankful to be on a train at all).

And the Proms too are very British in a plummy-voiced, middle class sort of way. Even if the acoustics were poor or the performance not up to scratch we could enjoy watching the people and engaging them in conversation. For example:
Me: 'What do you think of it so far?'
Plummy voiced character (PVC): 'Davis is perhaps a little too emotional. But I think the LSO is on form. Did you get to Cellini?'
Me: 'I heard it on the radio — we've come down from Newcastle.'
PVC: 'Ah yes, Newcastle. Not much in Newcastle.'
Me (defensively): 'There's the Northern Sinfonia ...'
PVC (lip curling): 'But it's not a proper symphony orchestra of course ...'

I gave up, but got in a dig about London's Millennium Bridge compared to Gateshead's. I don't think he'd heard of Gateshead.

But he was right about the LSO — and indeed its Chorus and most of the cast. They were incandescent. At the centre of this musical brilliance was Sir Colin Davis, 76 years old, resembling Berlioz himself with his unruly white hair, a man who has known and loved Les Troyens for more than half his life. And it showed in his magisterial command of the vast forces arrayed in front of him. Every detail of this extraordinarily complex score was lovingly displayed: the shrill wind and brass of the opening chorus of the Trojan people; the gorgeous clarinet solo in Andromache's mime (played exquisitely by Andrew Marriner); the terrifying octet and chorus responding to the death of Laocoon with its off-the-beat basses (the choral texture and detail here was a wonder); the raucous brass bands blazing out the Trojan March from the gallery, and too much more to describe.

It was, as the PVC said, emotional. This was a concert performance of a Grand Opera, but who cared? Petra Lang sang Cassandra, the Trojan princess who was cursed with a gift of prophecy that no-one would believe, with spine-tingling intensity. Her anguish at the fate she foresaw for her people was tempered by flashes of false hope, and by her tenderness toward Corebus (sung perfectly by William Dazeley as an honourable fellow who is no genius) the fiancé she knew she would never marry. Within minutes, eyes were being surreptitiously wiped (mine included). Among other fine things was the gloriously spooky, descending chromatic scale of the ghost of Hector wonderfully sung by Jonathan Lemalu from a disembodied position in the gallery.

After the smoke and darkness of La Prise de Troie, the start of Les Troyens à Carthage breathes sunshine, light breezes and prosperity. Michelle de Young was superb as Dido in her journey from proud and confident queen of Carthage, to the helpless lover of Aeneas who is so distraught by his leaving her that she commits suicide.

Unfortunately, one could not quite see why she was so enamoured of the Trojan hero, as Ben Heppner in the role was not on his best form and was emotionally too restrained, as well as causing a near disaster by missing some high notes in Act 5.

Along the way to the brutal ending, where the Trojan March overpowers the curses of the Carthaginians to predict the ultimate triumph of Rome (the descendants of the Trojans), we heard wonderful performances. For example, Toby Spence as the Trojan sailor Hylas was simple, elegant and moving and the two comical Trojan sentries were brilliantly done by Darren Jeffrey and Roderick Earle.

But to praise every gem one would have to describe the whole opera. All I can say is that after 5 hours I could have gone back and listened to the whole thing again. Truly one cannot imagine a greater musical experience.

Toby Lipman

Big doctoring in America — profiles in primary care
Fitzhugh Mullan
University of California Press, 2002
HB, 255pp, £19.95, 0 52022670 4

FITZHUGH Mullan takes us on a journey across America, introducing us to a cast of compelling characters — his 'big doctors'. We hear first hand about the lives, dreams and disappointments of 15 primary care practitioners. But mostly we hear about their work. Mullan hopes this character-driven approach will be helpful to those seeking insight into primary care in America. It works: the book is entertaining, thoughtful and at times provocative. It will appeal to clinicians, medical historians and lay readers. What is more — it is reasonably priced at £19.95 and only 250 pages long.

Mullan interviewed 74 'big doctors' in the late 1990s, asking about their work, what inspired them and what they thought about the American healthcare system. He turned the transcripts into oral histories — short autobiographical narratives — and deposited the collection in the National Library of Medicine. The 15 oral histories forming the core of this book are part of that collection. The narratives reveal an extraordinary group of people working in very different settings. Twelve of them are doctors, two are nurse practitioners, and one a physician assistant. Few of the doctors had a traditional career path and many do not work in settings corresponding to primary care in the UK. One San Francisco doctor, for example, sees mainly HIV positive gay men; another doctor is Dean of an osteopathic medical school. Nevertheless, many of the doctors seem to have developed a strong sense of social justice and at least two of them saw their religious beliefs as having a major formative influence in their lives and work. Most career paths were quite elaborate and many of the doctors had additional academic or administrative duties, with few spending their whole time seeing patients. Even fewer had spent their working lives in one place after completing medical training.

The commentaries, which Mullan adds to the beginning and the end of the book, are the least satisfactory parts. He wants to tell the broader story of the decline of the generalist (cast as the hero) and the linked rise to dominance of the specialist (cast as the villain) in American health care over the past 100 years. He believes this has caused the present inefficient, inequitable and fragmented system. This story is as compelling as the oral histories, but it is an oversimplification and fails to recognize the role of consumerism, markets, insurance coverage, political inertia and numerous other factors.

Among health professionals, those with a broader view of primary care including community involvement and multi-disciplinary working may find that this book has too narrow a focus. But for those who want some insight into the lives of primary care physicians in the USA, this book will be a valuable resource.

Ron Gray

Patients, power and responsibility: the first principles of consumer-driven reform
John Speirs
Foreward: by Karl Sikora, Radcliffe Medical Press, 2003
PB, 272pp, £27.95, 1 85775 924 9

IN this book with its topical and promising title, John Speirs is proposing that UK health care be no longer provided out of general taxation but be changed to a market-led structure in which 'we will see responsible personal choice among competing providers who can only secure incomes by seeking subscriptions from consumers with a free choice and who can only retain their loyalty by satisfying them' (page 138). There will be a core of patient guaranteed care or 'pretty good care', patient fund holding, patient guaranteed social insurance, patient guaranteed care associations and patient guaranteed care providers. The government will guarantee the structure funded in the main by general taxation. The individual will select an insurer and a care plan with a purchasing cooperative, to negotiate choices and to offer individuals the chance to provide additional supplementary funding.

The author, a champion of the Swiss, French and German healthcare systems in particular states that the social insurance systems in Europe shows that the poorest are treated immeasurably better with legally guaranteed entitlements to fuller health coverage. However, as elsewhere in the book there are no facts to support this statement. This is a pity as there is certainly a case for a clear explanation and comparison of the different European systems for funding health care with a critical examination of their strengths and their weaknesses. Furthermore the author could have discussed the social insurance scheme now running in the Republic of Ireland, a country not dissimilar to the UK. It is essential for the reader to have detailed information about how these social insurance schemes work, what is included and what is excluded before deciding whether to support the author's proposals for changes in the way our health care is funded.

In this scheme proposed by John Speirs, emphasis is laid on the importance of preventive care where the individual will receive incentives for improvements in, for example, blood pressure. The author suggests biannual meetings between patient and a doctor to discuss the individual's preventive care with a 'loading' potential on the premium for specific 'destructive life styles such as high consumption of alcohol, tobacco and lack of exercise'. A sort of revalidation of the patient! While the author accepts that staff would need to be trained for this he does not explain when GPs and other doctors would find time for these meetings nor discuss whether the patient would tell the truth.

The evidence to support the validity of patient fund holding is given as 'the revolution in ophthalmology ... financially empowered choice in health care'. The author believes in the UK optics market there is one experience for everyone with optics a public service managed privately within the government's framework of rules. The author suggests that the expanded role of optometrists in primary care has effectively reduced pressures on NHS waiting lists. Yet again there is not a critical analysis. While not in any way demeaning the very excellent work done by many optometrists, there is some disquiet among some patient groups that not all high street optometry chains will dispense the more complicated contact lens or spectacle prescription with the result that some patients are disadvantaged and some optometrists are not gaining wider experience.

If I had not been invited to review this book, I doubt that I would have persevered to the end. It was a difficult book to read. The polemic style and the very frequent use of sometimes obscure references in support of statements can be tedious and detracts rather than supports key points. This is a pity as John Speirs is making an important point.

Patricia Wilkie

Sex, death, custard and a load of balls: The 2003 Edinburgh Interr

The great American film director John Huston famously once called it 'The only film festival that's worth a damn'. Now in its 57th year, the Edinburgh International Film Festival has expanded far beyond its humble beginnings as a documentary film festival and for 2 weeks every August it brings the most exciting, innovative and dangerous cinema to Scotland. Truly international, the Festival can justifiably claim to have something to tease the palate of any moviegoer.

While 2003 may have lacked the more obvious must-see films of recent years when the buzz surrounding *The Full Monty*, *Ratcatcher* or *Amores Perros* eclipsed the films themselves, the Festival's commitment to dynamic new talent from around the world has never been stronger and for a change much of that talent was home-grown.

The biggest buzz this year surrounded David MacKenzie's second feature *Young Adam*. Adapted from a novel by Scottish Beat author Alexander Trocchi and playing like Last Tango on the Clyde, the film has the whiff of necrophilia about it as it charts a narcissistic failed writer's moral free fall. From its opening with a drowned woman being fished from the Clyde, the spectre of spoilt flesh haunts the film's brooding hero, Joe (human mannequin Ewan McGregor), as he drifts from one bout of joyless rutting to the next, wallowing in a hell of his own making. Already notorious for McGregor's less than romantic use of custard (in a scene that feels like it's wandered in from a Paul Verhoeven film), *Young Adam* is a cold beauty of a film, a numbing meditation on futility, guilt and despair that deserves the acres of newsprint it has already spawned, but it's a hard film to like.

© PA Photos

Wilbur contemplating the jump from Wilbur (Wants to Kill Himself).

Much more satisfying is the Scots–Danish co-production *Wilbur (Wants To Kill Himself)*, a touching black comedy about love, suicide and terminal illness. Self-destructive Wilbur (Jamie Sives) is barred from his support group and moves in with his eternally optimistic older brother Harbour (Adrian Rawlins). In between half-hearted suicide attempts and running their second hand bookshop, love enters the brothers' lives in the shape of shy single mother Alice (Shirley Henderson). But tragedy is waiting just around the corner... Sweet without ever being sickly, *Wilbur* is a gem of a film, beautifully written and directed, that never allows the bleaker aspects of the story to smother the gentle romance at its heart. While all the performances are strong, special mention has to be made of 11–year-old Lisa McKinlay who plays Alice's daughter, a very wise head on very young shoulders. *Wilbur* is a very human film, genuinely affecting without ever being mawkish or overly sentimental.

None of the films shown this year are going to rewrite cinema history but that's no bad thing. There were good films and bad, smart films and dumb, highs and lows. Clint Eastwood may have withdrawn his *Mystic River* at the last minute but there was traditional Hollywood fare on offer in movies like *Ned Kelly*, *Camp,* and *Party Monster*, a decadent portrait of the rise and fall of 1980s club kid Michael Alig (an angelic Macaulay Culkin). Richard Jobson's *16 Years Of Alcohol*, *Solid Air* and *Afterlife* along with *Wilbur* and *Young Adam* showed how diverse and vibrant the Scottish film industry can be.

Maverick director Jonas Akerlund (director of the Prodigy's *Smack My Bitch Up* video) transferred his grungy, pop video sensibilities to the big screen with *Spun* a frenetic, paranoid voyage into the lives of a group of Californian speed freaks. With its mix of explicit sex, wired to the moon animation and constant drug taking, *Spun* was destined for cult status long before Akerlund gave us the image of a constipated Mena Suvari defecating.

Far more sedate was *Torremolinas 73*, a low-rent *Boogie Nights* relocated to Franco's Spain. Audiences were charmed by this tale of a Bergman obsessed amateur filmmaker drifting into making cheap Super–8 porn with his wife and the image of a black-cloaked Death getting jiggy with the heroine gave *Young Adam's* custard cream a run for its money in terms of ludicrous sex scenes.

The 'Late Night Romps' gave us balletic, high-octane action movies from Hong Kong

and Korea with *Tube* (Korea's answer to *Speed*), *So Close* and *Yesterday*. There was genre-hopping sci-fi from Japan in *Returner* and from America came ironic gore in *Cabin Fever*, a film which gave us obnoxious teens in a cabin in the woods battling scary locals and a flesh-eating virus.

Elsewhere, Peter Greenaway came back from the dead with the ambitious, wilfully obtuse *The Tulse Luper Suitcases*, his single-handed attempt to reinvent the medium of film as a complete immersive experience with a project that encompasses feature films, TV, books, the internet and computer games, while Oliver Stone was remarkably coherent in a Q&A session following the screening of *Comandante*, his intimate documentary interview of Fidel Castro.

The subject of this year's Retrospective (titled *Hateful Man*) was the misanthropic Henri-Georges Clouzot who with *The Wages Of Fear* and *Les Diaboliques* proved himself a master of suspense to rival Hitchcock and whose 1943 film *The Raven* led to him being black-listed after World War II and accused of Nazi collaboration. Ultimately sidelined by the birth of the French New Wave, Clouzot's films are pitiless portraits of greed and frailty which reflect his own cynicism and his influence is evident in the work of Scorsese, De Palma and William Friedkin (who remade, unsuccessfully, *The Wages Of Fear*) and the generation of movie brats who are championed elsewhere in the Festival in the documentary *A Decade Under The Influence*.

For me though, the best film was *The Other Final*, a documentary that wore its heart on its sleeve (just below the captain's armband). Hilarious and touching, it chronicles Dutch filmmaker Johan Kramer's scheme to organise an alternative World Cup Final (on the same day as the real final) between the two worst football teams in the world, Montserrat and Bhutan. His obsession takes him from Europe to the Caribbean and finally the roof of the world, the Himalayas, encountering along the way footballing policeman, a prime minister who is also the manager of his country's national side, Zen archery and the most irritating football song in the world.

Quietly profound, the film never mocks its subjects and gives the audience a real David and Goliath story where there are no losers. *The Other Final* is the reason why film festivals exist; without them films this good would be relegated to Channel 4 in the wee small hours. Festivals should be a celebration of the possibilities of cinema and a platform for unique and talented voices.

This year, Edinburgh came pretty close.

David Watson

roger neighbour *behind the lines*

On performance

If it's still on when you read this, and if you possibly can, catch Tom Stoppard's *Jumpers* at the National Theatre. This farce, which I saw premiered in 1972 — oh God!, the year I started vocational training — this ever-fresh farce brings into unlikely collision the disparate worlds of philosophy and acrobatics.

George our crumpled hero, stunningly played by becardiganed Simon Russell Beale, is that GP of the academic world, the Professor of Moral Philosophy. He is flagrantly cuckolded by the smooth-talking consultant-resembling Archie, Vice Chancellor, psychiatrist and amateur acrobat. Another member of the acrobatic squad has been inadvertently shot by George's wife, Dotty. Complications, as they say, set in.

I love wordplay, and Stoppard's delicious linguistic pyrotechnics have me in heaven. For example: George, an amateur archer, soliloquising on Zeno's paradox, convinces himself that 'though an arrow is always approaching its target, it never quite gets there, and Saint Sebastian died of fright.' Laugh? Till the tears ran down my leg.

Why am I telling you this? Several weeks have gone by since I saw the play, and like all good art it's left something behind inside me, niggling away. It is hard to put into words; bear with me.

Many GPs find their work engenders a form of spiritual fidgeting, a reaching-out for deeper meaning, an inclination to squeeze a little significance out of life's spitefulnesses. As doctors, we are valued for the empathic way we can come alongside individual people in their individual extremity, and simultaneously for our role as the wise and detached professional. It comforts patients to think we can see the big picture while they carry on suffering the small ones. For a doctor to view patients' predicaments as so many wrinkles in the fabric of the universe is not callous or dismissive. It helps; for if we can take them in our stride, then — by proxy — so can they.

In a word, the job makes philosophers of us, philosophers of the Stoic persuasion. Since we too are mortal and made of wrinkles, it takes a lot of practice to look uncrumpled, to act unfazed. And there is a sense, too, in which we must be acrobats. Good doctoring calls for balance, timing, cooperation and agility — if not of the body, at least of the intellect. The dropped catch, the fatal plummet is only a fumble away.

I think the niggling heresy with which Stoppard has infected me is the wish to recognise general practice as a performance art. I don't mean simply in the 'All the world's a stage' sense, which holds people, ourselves included, to be no more than the portfolio of roles in their repertoire. Anthony Rooley, in a book on performance[1], takes the Shakespearean view, seeing all our actions, every interplay of relationships and pursuits of all kinds as 'performance'. 'At times,' he acknowledges, 'it seems as though such a view may take all spontaneity out of everything, only for us to discover that potentially it leads to yet greater freedom.' Rooley suggests that 'if we play our roles with ease, unselfconsciously, with love and care, then through our play we may blossom, and those around us too.'

If we buy into the idea of 'general practice as performance', and its corollary that GPs are actors, we must also accept the problems that go with it. Not least is the fundamental irony every actor faces — if he[2] is to move the audience, he must himself remain unmoved and in command of his performance. This is an old chestnut. The 18th century French man of letters Denis Diderot argued[3] that great actors must possess judgment and penetration without 'sensibility' — that is, without actually experiencing the emotions they are portraying as characters on the stage. For to do so would be to lose the ability to lift the audience or patient to yet greater insights. Diderot asked how the actor is to catch just the point at which he must stop being himself and become the practitioner of a contrived and well-rehearsed skill. He couldn't answer his own question; but then, he had not had the benefit of being in a Balint group.

That great theatre takes place, albeit unwitnessed, in the consulting room few will deny. Occasionally Shakespearean in its import, it is more often Ibsen, or else Alan Bennett. No stage or TV drama has quite captured the cameo subtleties of the two-handers played out between GP and patient every 6 minutes. Yet the consultation provides a ritual which (to quote Rooley again) 'in the moment of performance has relevance for our entire lives. The experience of performance contains such powerful things: heightened states of awareness, moments of incredible clarity, profound admiration and respect.'

Applause? No no, modesty forbids …

1 Rooley A. *Performance: revealing the Orpheus within*. Longmead: Element Books, 1990.
2 Sorry about the sexist pronouns. When the English language cracks it, let me know.
3 Diderot D. (1713-1784) *Paradoxe sur le comédien* [The paradox of acting]: written 1773, published 1830.

matters arising

The Small Dispensatory
Sabur ibn Sahl — translated from the Arabic by **Oliver Kahl**
Brill Academic Publishers, 2003
HB, 242pp, EUR 79.00, 90 04 12996 0

TRAVELLING in the mind as well as body is one of the great expectations of a good holiday, and my baggage allowance is always endangered by a stock of books in the summer vacation. Tucked between certain cult texts of magical teenage fiction (which I felt obliged to read purely for anthropological purposes), and Eliot's *Daniel Deronda* (the closest I allow myself to get to classic romances), I was privileged to be taken on an entirely unpredicted journey by this slim and scholarly work.

It transported me to a time when, while Western Europe was still trying to upgrade its agriculture from hunter-gathering, the cultures of the Middle and Far East were already sharing complex therapeutic knowledge through written translations and personal exchange (page 10). Kahl raises an interesting point in the introduction when he notes that a work of this nature could only become possible when a language reaches a certain level of formality and consistency capable of expressing formal theory. Again, this points up the sophistication of the Arabic culture at a time when, together with China, India and Greece it constituted the core of civilisation.

Sabur ibn Sahl (d. 869 CE), the author of the original text, was an Iranian whose fame was derived from his practice as a physician at the court of the Abbasid caliphs in Samarra in Iraq, and who in particular was celebrated for his expertise in pharmacology. The work is largely therapeutic recipes, based on a truly exotic range of ingredients denoting the global trade in which Arabia was even then engaged (page 16). As with contemporary drug formularies (such as the BNF), there is no intellectual attribution of the recipes to those many who must have shared their experience with ibn Sahl: one assumes that his personal choice of therapies was sufficiently unique to justify his authorship, and that his choice to record this for posterity was the defining step in making the dispensatory his own, subsequently to be adhered to and modified by others (page 29).

Every paragraph implies a wealth of scholarly activity — from the transcriber of the text after the death of ibn Sahl (page 14), through to the efforts to locate and identify its author, and Kahl's own programme of work on Arabist literature, including this translation into English. The most impressive scholarship is that of the physician himself, who also wrote a 'large' dispensatory; presumably this one is the 'Vade Mecum' of the Arab practitioner? Reading the dispensatory made me acutely aware of the lifelong effort required to perfect and transmit a body of clinical knowledge, especially when working across language barriers. Kahl notes that the languages of the text (and for himself when annotating and verifying) were at least Arabic, Syriac, Greek and Persian/Sanskrit (page 24) — impressive to me, having witnessed the extreme difficulties of native English speakers to converse in any other language at international conferences. All this must be set alongside time commitments to clinical practice and treatment preparations — some of which needed 6 months plus to mature, after pounding, kneading, straining, melting and a host of other mixings and measurings. It is always tempting to assume that we work harder than any physicians before us, but the vivid picture of ibn Sahl conjured by his dispensatory made me wonder if this is true.

In fact, it is the joy of studying the history of medicine that comparisons enable us to evaluate our own otherwise taken for granted assumptions about contemporary practice. This book is immersed in the Galenic tradition of humours (pages 6–7), the need for balance, and above all an emphasis on homeostasis which, in embracing environment and 'the passions of the soul' (page 11), may truly be regarded as

holistic. The fact that our own models of health and illness barely relate to these therapies shows how deeply treatment is linked with the cultural assumptions and approaches of an historical period. I expect that a reader 1000 years from now would struggle to recognise the bioscientific paradigm which we currently assume defines 'reality'.

Potential readers should be clear that the bulk of the text is recipes, but that evaluation of their potential clinical efficacy falls outside the scope of this book. The personality of ibn Sahl and his patients are absent from the book, because very little exists about either; and the context and impact is largely conveyed by Oliver Kahl's intelligent and restrained introduction. Those looking for an action packed plot, or indeed even a commentary on the clinical practice of the period, will be disappointed: this book is more like a work of art, whose impact is subliminal, and whose significance for medicine is hard to define. I recommend it primarily because it reminds us of the generations of physician and scholars whose efforts precede our own; because the image of the dispensing is so artistic and uncommercial; and because it is humbling.

It also, in these troubled times, caused me to reflect on the impact of disruption of clinical learning due to political conflicts. What if Sabur ibn Sahl had been unable to discuss his work with his Indian and Chinese counterparts? Not been able to get his Celtic nard, Malabar cardamom, or Yemenite alum because of international sanctions? Been disallowed from practice because he was of an unfavoured race? Been unable or unwilling to learn other tongues because of cultural parochialism? I doubt that Kahl intended these to be the key lessons derived from his work, which in the end is a specialist Islamic text. It is, nevertheless, a book both delightful and salutary.

Amanda Howe

neville goodman

Bits and puddings

WHAT is it about children and bits? We were having breakfast in a hotel not usually overrun by children: it's a quiet town house hotel, more usually frequented by business men and women in the week and at the weekend by the sort of couple who come down very late to breakfast. It was the weekend, we were not late down, and we were followed into the breakfast room by three serious looking girls who could only have been sisters. Staying in the hotel was obviously a treat for them, and being allowed down for breakfast without parents even more of a treat. They carefully selected a table for three and sat down. Only one was tall enough for her legs to reach the ground.

The waitress approached and asked if they wanted orange juice. There was a short pause before the eldest sister asked, 'Is it real orange juice?'

The whole dining room held its breath. A collective smile greeted the inevitable, 'Has it got bits in?'

It didn't help to ask some experts on the subject (two nieces) what the problem was with bits. One claimed to like bits; the other just said the taste was 'funny'. As the bits taste no different from the juice, this makes no sense to the adult mind. It must be down to texture, but what about some of the other things that children are happy to put in their mouths, such as particles extracted from their noses?

Hotel dining rooms are eavesdropping heaven. Medical matters seem to need a loud voice: do these diners imagine that no one can hear their tales of operations gone wrong? Or are they hoping for an unsolicited second opinion, because it is difficult sometimes not to leap up and say, 'Look here: I'm a doctor and what you've said is nonsense!' The woman who stated authoritatively, 'Cold drinks in hot weather only make you hotter, because your body has to heat the water up,' really did deserve a tutorial on the laws of thermodynamics — or at least her companions did.

Americans are especially prone to medicine at dinner. One loud couple had bored the whole dining room at dinner with discussions of their blood pressures and various of their glands. They started up again at breakfast. It was the sort of hotel that provided a comprehensively delicious cooked breakfast, including black pudding.

'Say,' said the husband loudly to the waitress, 'What's in this black pudding anyway?' And she told him. After which he remained pretty quiet for the rest of the meal.

our contributors

Stephen Abbott, **Jane Bentley**, **Anne Lanceley**, and Professor **Julienne Meyer** all work as researchers in the School of Nursing and Midwifery, City University, London.

Ron Gray has moved surprisingly from the notorious decadence of Glasgow University Union, through forensic psychiatry, to public health. He moves shortly from Harvard to Oxford as a Senior Clinical Research Fellow in the National Perinatal Epidemiology Unit. **rgray@hsph.harvard.edu**

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'By a bizarre turn of fate' **Toby Lipman** has been persuaded to become chair of the Northern Faculty of the RCGP. He encourages all members to attend the Andrew Smith lecture, on Nov 13, by John Spencer, who will affirm that general practice should be the destination of choice for new docs. He's right, of course. **toby@tobylipm.demon.co.uk** **http://www.eb-practice.fsnet.co.uk/**

Roger Neighbour is spending too much time in France at present. That will change as he adds PRCGP to his letterhead, if he is so inclined ...

Karen O'Reilly is a GP in Alton, Hampshire — **karenaoreilly@hotmail.com**. Firmly acquainted, we are led to believe with ... **Matt de Quincey**, also an Alton GP. What is it about Alton that fast-tracks publication in the *BJGP* ..?

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Patricia Wilkie has chaired the RCGP's Patients Liaison Committee (since re-named with a more politically correct acronym) but now lurks on GMC and should be approached with due deference. **pwilkie@inqa.com**

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jill thistlethwaite

A new horizon

JULY, North Queensland, Australia. It is mid-winter and 27Þ Celsius. The sky is blue and the sea is calm (and at this time of the year empty of box jellyfish, the most poisonous creatures on the planet).

I am here on a fact-finding mission. Those of you who read my last column might remember my ambition to work abroad. So the fact I am trying to find is whether I would like to work here. The weather is definitely a major factor in the decision-making process. However, the locals — to scare me off perhaps — warn of the heat and humidity of summer. Rather more frightening for the locals however, would be the sight of my tall gangly husband in the informal work attire of shorts and loud shirts (I hope he doesn't read this).

A local GP and academic tries to explain to me the intricacies of the Australian health service. Terms such as 'Medicare' and 'bulk billing' are difficult to untangle. It appears several systems run in parallel. The one concrete fact is that home visits are a thing of the past … usually. The local practice where I would work if all things come to pass, like many here, is short of physicians; and there has been no female doctor for a while. That's ok I think, until I discover that doctors do most of the cervical smears and recall is 1–2 years. There are practice nurses in some places, but they seem to be restricted to the tasks our nurses carried out over a decade ago.

The Department of General Practice at the James Cook University in Townsville is responsible for undergraduate and postgraduate training programmes across the north of the state. This includes providing continuing professional development for the 70 GPs who practise in an area the size of England and Wales. Videoconferencing is the main point of contact. GP registrars are attached to one-doctor towns separated from their peers by hundreds of miles, — oops kilometres — of outback. They seem to relish the challenges of this isolated life, but whether they will want to continue to work this way after qualification is unclear.

The shortage of qualified GPs is a major problem. The fellowship examination of the Royal Australian College of General Practitioners (RACGP), equivalent to British membership, is the mandatory endpoint of vocational training. Owing to the need for more doctors the RACGP has recently relaxed the rules for the right to practise of foreign graduates. Possessing MRCGP is now considered to be a sign of competence. This has caused some ill feeling among Australian GPs who still find it difficult to have their postgraduate qualification and experience recognised by the JCPTGP.

Doctors without general practice certification are allowed to work in areas of need for a limited time, but receive lower item of service fees. They are expected to do the fellowship within a certain number of years. This means that the least culturally attuned and experienced doctors are working in remote areas and they tend to treat only acute problems, neglecting prevention.

The undergraduate medical course at the university is now in its fourth year. The curriculum is community focussed and the aim is for students to learn a high proportion of their medicine, surgery and other 'specialities' in general practice. Ultimately it is hoped that the resulting doctors will work in the state and ease some of the workforce problems. There are huge deficits in the provision and uptake of services by the Indigenous population. The week before I left on my trip *The Guardian* ran a story about race riots in Townsville.[1] This caused a major upset in the city and denials from the mayor.

Other random thoughts: David Beckham is also ubiquitous here, Australian television programmes are interrupted by adverts every 10 minutes, people are very friendly … and did I mention the weather?

PS: I'm off to live there before the end of the year.

Fickling D. Race hatred polarises Australian town. http://www.guardian.co.uk/international/story/0,3604,982046,00.html (Accessed 9 September 2003).