# The Back Pages

## viewpoint

### Turning the tide on drugs

DRUG users can challenge those of you in general practice to muster all your resources, but like it or not, they are here to stay, and in ever growing numbers. The number of addicts rises by 70% every 4 years — that means potentially more than half a million by the next general election. Heroin and morphine related deaths rose by 110% between 1995 and 2000, and cocaine-related deaths quadrupled. All the drivers are worsening to the extent that drug agencies are now seeing clients whose habits are life-long; some are even talking about the need for specialist elder care.

So what can be done? General practices still engender high levels of trust and represent one of the few remaining local institutions people like using. Of all the health services, they tend to be better at seeing patients as individuals — with complex aspirations and behaviour as well as medical needs. Practices also have the potential to be better networked locally and able to engage patients in a wider range of help and life-changing activities — though few exploit this fully yet. And the incoming GMS contract offers new opportunities to deliver services creatively. Whatever one's personal views, general practice is at the front line of action on drug use, even though it cannot possibly solve all the problems alone.

First, we must recognise that problematic drug use (not weekend pills and thrills) is at once economic, social, and cultural, as well as a matter of health. The correlation between problem use and deprivation, for example, is staggering. One study showed that drug-related hospital admissions from the most disadvantaged areas of Glasgow were 30 times those from the most affluent. Another analysis of national data confirmed that an individual's likelihood of addiction increases in step with the level of personal deprivation — with the most deprived at 10 times greater risk than the least. If we are to curb the most damaging drug use, we need to help people change many aspects of their lives not just their drug use; to address causes as well as symptoms.

To do this, we must get better at treatment. Presently, few drug users consider GPs to be their allies. About a third are excluded for being too erratic. A further third drop out of treatment part way through. Others go back to using street drugs because methadone maintenance is rarely that, and some feel unsupported on routine underdosing. It is time drug treatment became accessible and professional instead of rigid and judgmental.

Next, general practices must learn to be more effective, strategic advocates of their patients' needs — their knowledge and perspective make them ideally placed to do this. So go upstream to the primary care trusts charged with improving public health and negotiate new ways of working. But also try to involve the public and voluntary agencies and the new breed of social enterprise that can offer housing, advice, training, and work. In this respect, the UK needs to learn more from international best practice — such as drug projects in Asia which successfully combine treatment with social care, arts, sports, training, and business, rehabilitating and employing large numbers of former street users in the process. These services are much more effective than most UK offerings but to create them here, we need to enlist the enthusiasm and expertise of a far wider range of agencies. We live in an era of 'evidence-based' policy and practice development, so let's learn from the third-world evidence and build broad-based services that can begin to tackle the deprivation and wider problems instead of focusing on drug use alone.

Finally, to be proactive about drug use, general practices need to act as a gateway, as well as service provider. Your patients trust you, you're their first port of call, so use the opportunity that presents to persuade drug users to begin to look after their wider interests — whether that's a forgotten talent at painting or an urgent need for a dentist — and begin to develop a sustainable pathway to recovery for themselves.

There is certainly a lot to be done — but we should feel optimistic that we can make inroads on a problem that has in the past proven intractable. If we act on a proper analysis of the problem, and link up the range of practical initiatives that together have shown themselves to produce the sort of outcomes we're looking for, we can change the spectre of drug abuse for good.

**Rowena Young**

**Further resources**

This piece draws on analysis developed more fully in: Young R. *From War to Work: drug treatment, social inclusion and enterprise.* London: Foreign Policy Centre, 2002.

Also recommended for a comprehensive review of the evidence: Advisory Council on the Misuse of Drugs. *Drug misuse and the environment.* London: HMSO, 1998.

For fresh thinking on treatment models for stimulant users, contact the National Treatment Agency for details of their pilots with crack users — http://www.nta.nhs.uk.

## contents


898 IT 1
viewpoint 2
Videoconferenced consultations — lessons from Australia
Thornett, Evans, Sandars
899 flora medica
900 IT 2
The Inner Computation
Andrew Sharp
plus Blair Smith
The philosopher of the Ring, II
902 IT 3
postcards 5
Blogging
Douglas Carnall
904 rural practice
Santiago de Compostela
Wales
906 digest and reflection
Breath-taking poetry, supervision,.support, and the stiffness of cadavers...
Blair Smith, Antonio Munno, Surinder Singh,
plus Neighbour on vocation
910 matters arising
UK Council report
plus Goodman on management speak
912 our contributors
plus Munro on enlightenment

**On videoconferenced consultations — lessons from Australia**

WHAT do we do when there are no urgent outpatients appointments available, or the distance is to the nearest clinic is too great for our patients? Pressure on NHS clinics is mounting and there is an increasing drive to discover new ways to meet patient demand.

In a report to the NHS Executive, Purves *et al* suggested that videoconferencing could provide benefits in these situations.[1] Such technology may enable patients to consult a specialist while in their GPs' surgery with the GP present, and the consultant in his or her own office at the hospital, regardless of time or distance constraints.

In addition, doctors can give medical attention to isolated patients for such purposes as teleradiology, telepsychiatry and teledermatology. The NHS Research and Development Programme identified the need to research this area in 1999,[2] and has begun to fund projects.[3] In anticipation of the benefits that these new technologies will be able to deliver to UK health care, private companies are already developing appropriate solutions. In the UK, British Telecom opened the country's first dedicated Telemedicine Centre, open to healthcare professionals, and has been involved in using videoconferencing to link nurses working autonomously in a minor injury unit to doctors in other hospitals within the Worcestershire Acute Hospitals NHS Trust.[4]

But is this the most appropriate answer to difficulties the NHS is experiencing in providing specialist advice elsewhere in the country?

When initially viewed, these initiatives seem to provide the perfect answer for the NHS's deficiency of specialists. Reduced costs for patients with reduced travel and time off work, reduced costs for the NHS with less need for consultants to travel to clinics in outlying towns, support from the GP who can be present in the consultation and better continuity of care, an educational opportunity for the GP where the GP does not need to leave the surgery to take part, the potential for CPD activities using the video link once installed, the patient is seen on familiar territory rather than having to travel to an alien environment, and easier to involve patients with poor compliance or whom are difficult to persuade to travel distances.

In South Australia, videoconferencing has been successfully introduced throughout the State. Every rural hospital is linked by video to a teaching hospital, and without doubt these links provide vital access to specialist services in areas where secondary care would not be otherwise available without travelling for several hours.

However, the Australian situation is different from that in the UK in a number of ways. Some towns are up to 8 hours travel by road from the capital, Adelaide. In addition, some specialties are not available in rural towns except through this method, a problem that has been experienced particularly in the case of psychiatry, for which these consultations are often used by local psychiatric nurses. This lack of specialists is exacerbated by a healthcare system that allows doctors to choose to work in the capital and is unable to distribute expertise across the State.

Such distances are unusual in the UK. Apart from some localised areas, patients in the UK have same day physical access to a specialist in an emergency in most areas, removing this justification for introducing this new technology.

Do the other potential advantages of videoconferencing justify its introduction in the UK?

Recent work has found that the potential cost benefits of the technology are often not seen in practice.[5] The time needed to set up equipment and conduct the consultation is often much greater than expected, and consultants are often not confident in the decisions they have made, leading to increased follow-up rates. Further costs relate to the need to train staff to set up and use the equipment. Investigations arising from consultations still need to be conducted at traditional locations, meaning that patients may still need to travel.

Concerns have also been expressed about confidentiality issues in relation to the use of emerging technologies in health care.[6] These are particularly exacerbated by risks of hacking into networks, and the effect of spy-ware and viruses on computer systems. In addition, difficulty establishing connections means that a back-up system needs to be available that does not require the videoconferencing system.

In spite of these concerns, the South Australian experience has demonstrated that there are significant educational benefits for this technology, particularly

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for isolated healthcare professionals. In addition, there has been improved access to high quality care in disadvantaged and remote areas where experienced doctors may not wish to work.

New technologies are likely to bring new benefits in the future. Increased use of broadband technology is likely to lead to increased access to high quality video and allow transfer on-line in real time reports and investigation results, including photos and x-rays. This will improve consultants' confidence in their decision-making and lead to increased use of the technology in everyday practice.

So should we introduce videoconferencing in the UK? The technology would allow primary care teams to participate in centrally run educational activities without having to close the surgery. This would be of particular use to isolated single-handed GPs where cover to allow professionals to take time off to attend educational activities is difficult to find. In addition, the technology can be particularly helpful in remote areas, allowing patients to have access to secondary care services without the need for travel.

However, this is not the answer to inadequate service provision in much of the UK, where insufficient availability of outpatient clinic appointments needs to be resolved by increased funding. If anything, videoconferenced consultations take up more time and require a dedicated room in both surgery and hospital, reducing the available space and time for other consultations.

The new technology should be introduced with care. It is a useful tool that represents one way of accessing specialist opinions, but needs to be introduced as part of a comprehensive set of measures that provide appropriate solutions for different areas.

**Andrew Thornett**
**Alan Evans**
**John Sandars**



**From the journals, September 2003**

***New Eng J Med* Vol 349**
**941** The search for the secret of appetite control goes on: a few years ago we had leptin, last year we had grehlin, and this year it's peptide YY3-36, or PYY. The more PYY you have, the less pie you eat.
**975** Addiction is a complex process by which soft-wiring for pleasure becomes hard-wiring for need: here's a useful account of the complex neurobiology.
**1019** A large study of stroke outcomes in patients with atrial fibrillation confirms warfarin is better than aspirin, and that the INR (International Normalised Ratio) needs to be kept above 2.
**1133** Antiphospholipid syndrome is fairly common and can be devastating: patients with it also do best on warfarin with an INR between 2 and 3. The editorial on page 1177 is the best short account I have come across.
**1207** The best treatment for osteoporosis is parathyroid hormone (PTH). On its own, it beats alendronate: adding alendronate to PTH gives no added benefit in women and may even reduce its effect in men (page 1216).
**1227** Another paper which refines the use of D-dimer as a test for deep vein thrombosis (DVT). In low-risk patients, this blood test alone can safely exclude DVT, without the need for ultrasound.

***Lancet* Vol 362**
**759** A series of papers from the CHARM study establishes the place of candesartan in heart failure, and by implication the role of angiotensin receptor blockers as a class. They can be used to substitute for ACE inhibitors in systolic dysfunction, but combination therapy works even better. However, in patients with heart failure without left systolic dysfunction, there is little effect.
**782** A study of perindopril, replicates the message of the HOPE trial — give ACE inhibitors to everyone with coronary artery disease.
**789** And those who have had myocardial infarction should be on the thrombin inhibitor ximelagatran as well.
**1053** Lots of drugs for heart failure, then, but what about the other cause of breathlessness in elderly smokers, chronic obstructive pulmonary disease? Plenty in the pipeline, according to this useful overview of the condition.

***JAMA* Vol 290**
**1157** Our dear Royal College can take much of the credit for introducing communication skills training in the UK, and it works in the USA too, as shown in this study of medical students.
**1173** But general practice is very low on the list of career choices by US medical students — what they want is a mixture of high income and high autonomy.
**1323** Sedentary overweight women get fitter and lose weight if they combine modest amounts of exercise with dieting.
**1331** And exercise also reduces the risk of breast cancer in postmenopausal women.
**1459** Although there is much evidence suggesting a role for *Chlamydia pneumoniae* in acute coronary events, most trials of antibiotics have had no effect, like this one using azithromycin.
**1500** Beware recommending St John's Wort to patients taking other drugs — it interacts with about 50% of them.
**1633** How do you diagnose otitis media? Here's the evidence, in another of *JAMA*'s invaluable but sporadic Rational Clinical Examination series.

***Other Journals:***
*Arch Intern Med* reports that early trials of lipid-lowering drugs seemed to show higher rates of suicide, but statins usually make people happier (**163:** 1926), and a new Framingham analysis confirms the strong relationship between total cholesterol and lifetime risk of coronary disease (**163:** 1966). Can you eradicate *Helicobacter pylori* in a day? Probably (**163:** 2079). *Ann Intern Med* (**139:** 476) looks at the effectiveness of thiazides in preventing hip fracture: impressive, but you need to keep taking them. Whooping cough is still around and still kills children: *Arch Dis Childhood* (**88:** 802) describes a series of severe cases in London hospitals from 1998–2000. Also common and underdiagnosed, is streptococcal infection in children with sore bottoms (**88:** 811). *QJM* (**96:** 673) looks at a treatment for stroke which works in animal models, but has been little studied in humans — dexamphetamine.
This week's special: sizzlin' chargrilled bovine thyroid with large fries and a free drink. Apparently that's what you sometimes get in a Canadian hamburger. Recurrent hamburger thyrotoxicosis is described in *Can Med Assoc J* (**169:** 415).

**Plant of the Month: *Hydnum repandum***
Actually not a plant but an edible fungus, known as the hedgehog because it has little spines under the cap, rather than gills. Creamy yellow, so easy to find in the woods; and unmistakable, so safely eaten.

## The Inner Computation

It's the first health surgery after Christmas, 2024, and before I 'blip' to call through my first personal health client, I ask Candid, my computer, how she is feeling this morning.

'Very well, thank you, and how are you?' she says in a happy-to-hear-you-again voice.

'Could be better,' I say, wondering if the metastatin polypills are making me feel less than health optimised.

'Any presents for Christmas?' says Candid, as I activate the switch for the total health analyser under the health client chair.

'This book called *The Inner Computation* by Kylie Faber.'

'Interesting?' asks Candid.

'It's about the "computer-centred consultation". We personal health physicians have become so focused on our personal health clients in consultations that we no longer give enough attention to our computers and so fall down on our health facilitation ratings.'

Candid doesn't comment immediately — she has limits to her understanding, or maybe she's communicating with the Primary Health Foundation (PHF) computers — so I go on.

'Things have changed. Around the turn of the century, when computers were little more than prescribing and data recording machines, studies showed that consultation time increased with computer use without benefit in patient satisfaction. More worryingly, some patients saw the computer as an intruder in the consultation. The computer made the consultation less patient centred and more doctor centred.' [1,3,4,5]

I look towards Candid, 'All I can see of you is the screen flatly integrated into the desktop, but when I was a young principal I could hardly find space for my notes on the desk, what with monster screen/keyboard/mouse/fluff/coffee stains, plus connecting coils of wires. Neither doctor nor patient could ignore the computer. Too easy to look at the screen and lose eye contact with the patient for long periods of time. The amount of time during which the doctor did not interact directly with the patient was increased by computer use. A study in the 1990s stated that all the doctors who saw video footage of themselves consulting were surprised at how much the computer altered their interaction with the patient.[2] So much so that they all resolved to change their behaviour concerning the use of the computer.

One doctor said, "Yes, damn it, I really am looking too much at that screen. You see I had no problem with that computer until you came and recorded those videos." Another said, "It was my job to listen to her at that moment. But at the same time I was looking at the computer screen …" [1,2]

Candid is quiet, but glancing at the screen I notice that the first health client has already entered health concerns and Candid is displaying 'question suggestions', which have proved very discriminating for similarly matched individuals, and flagged up the anniversary of the death of the health client's brother. Candid keeps a record of everything I say (usually with the 'frustration outburst filter' turned on between clients) so I speak the command 'trawl Medline', and know she will make a list of articles that are most relevant to my monologue.

'However, it wasn't all bad news. Even then, if verbal skills and eye contact were maintained, patients didn't think that the computer led to a loss of the personal touch despite ponderous input methods and limited uses.[5] They also found that doctors who showed the patient what they were doing on the computer, or even just showed them what they were looking at, were rated more highly. I was amused to read that a patient said: "What is he looking at that thing for? I don't know, I really don't know."[2] They found that telling the patient what the computer was used for was worthwhile, but it also helped the doctor to be more aware of the reasons for using the computer at that specific moment.' [2]

A voicemail icon is flashing, so I pause to listen to the PHF target optimiser announce that blood pressure targets for all health clients are reduced to 110/70 mmHg, but no extra Euro payments to the practice. I'll discuss that with the others over the vidi-screens later.

'Go on', says Candid.

'Another worry patients had was loss of confidentiality.[5] Makes you laugh now, when it's entirely the health client, or their information advocate, who control access to their information? But in those days it was a very legitimate concern.'

'Let me see,' I say, going to a 'post-it' note in the book (that's one thing that hasn't changed). 'Here is another quote from a patient in those days: "Yes, that's right, he is looking a lot at that thing; it's as if he is seeking help from it, or is he keeping something secret in there?" ' [2]

Candid interrupts saying, 'Excuse me,' and I see that she has done well with trawl Medline and is displaying a message that states: 'It was not until 2005 that a study showed conclusively that consultations were becoming more efficient by use of computers.'

'Well that's history now,' I say, 'but *The*


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*Inner Computation* says that with the latest advances in technology we'd be using you computers more; for example to chip in with pros and cons of therapeutic options, and which specialist practitioners have the best results. You can now give us up-to-the-minute conclusions from the National Institute of Computational Excellence for optimal drug combination and dosage for individual health clients, proteome-specific. You can be so much more authoritative than the doctor and so we can leave you to do the explaining to the health client in your consultant voice mode and keep the doctor's role purely empathetic, or interpretive of your comments. Even in 2003 some health clients felt that the computer was helping the doctor to make better decisions — in prescribing at least, though early attempts at decision-support tools based on care pathways and simple algorithms were largely ignored by the majority of doctors because they were slow to use and couldn't match the doctor's experience and the particular health client circumstances.'[6]

'What about this?' says Candid.

'Read it to me,' I say, fiddling with the air conditioner, *de rigueur* in Leicester post global warming.

'Computers were used by the doctors for "time-out" in the consultation — for moments when they seemed to need a break to solve a problem or to get a rest from interaction with the patient.'[2]

'That's funny, regarding the problem solving comment,' I say, 'because in those early days it's unlikely that the computer would have been able to help much — they just displayed pages of information rather than the health client-specific stuff we get now. *The Inner Computation*'s premise is that we should be using "time-out" with the computer much more than we do — although it is the health client who should be offered to take the lead in interacting with you. We doctors just facilitate the process.'

Candid says, 'You had better get on. Mr Finch has arrived.'

Mr Finch enters. I welcome him and say, 'I have a couple of questions to ask about the health concern notes you entered yesterday.'

Mr Finch gets out a piece of paper and says, 'I didn't mention everything in my health concern notes. I have a bit of an extra list here.'

I keep my attention on Mr Finch while I jot down his list, my hand resting on Candid's screen. As he finishes I write: 'Help me out please, Candid,' and then, remembering a few lessons from *The Inner Computation*, say to Mr Finch: 'Well let's see how the computer can help me to help you.'

**Andrew Sharp**

## blair smith

**The Philosopher of the Ring — Book 2. The Governance of the Ring**

THE scene is an upper room of Ivory Towers. A layer of light cloud has settled at about head height, assuming that the head in question is associated with feet that float higher than 1.96 standard deviations from the ground. The atmosphere is rarefied. The professor and the R&D manager are in conversation, and inspirational sparks are flying ...

'... the thing is,' said Albert, the professor, 'there are just too many people doing research.'

'I know,' said Isaac. 'Soon anyone will be able to do it. Then where will we be? We'll have lost everything — our intellectual hierarchy, our sense of mystery, our trips to Geneva, our *raisons d'etre*. Even our respect. You know, only the other day I caught one of my partners using Medline. He was actually doing a literature search! And they're all talking about RCTs and cohort studies. I'm going to speak to the Union rep — they're clearly beyond their remit.'

'I mean,' said Albert earnestly, 'it's not as if they'd ever catch you seeing a patient. We should all stick to our own patch. What can we do to stop it?'

There was a pause, as the two academic minds began a session of focused thought and umbilical scrutiny. Eventually:

'A fantastic idea!' exclaimed Isaac.

'Yes, go on,' encouraged Albert.

'No. I mean that's what we need — a fantastic original idea. I haven't had one yet, but at least that's a starting point.'

'Yes,' said Albert. 'You're right. An idea that's so original, no one's ever thought about it before; and so fantastic, no one will ever believe it. But what?'

A further wonderful pause, during which intellectual juices fuelled the fire of inspiration, and the two minds connected in an almost physical way, sending fireworks into the evening sky. You would have been amazed to see — no — feel it. As one (which, now, in an academic sense, they were), they simultaneously uttered the definitive word:

'Governance!'

'Yes,' said Isaac. 'Research Governance. We invent it, write to everyone, and implement it. And we design so many rules, and make everyone spend so much effort proving their adherence to them, that no one will have any time to do research even if they can get around the rules.'

'It's brilliant,' said Albert. 'It worked perfectly with Clinical Governance. It's bound to work for research. We'll insist on confidentiality statements so strong that no one will be allowed to know who signed them. We'll require all projects to be formally approved on a daily basis by the Minister for Health. And we'll need anyone contemplating research to be examined and approved every 6 months by a special Committee ...'

'... that meets every second year. Yes, and any application to the Committee must include the signed agreement of every potential research subject and questionnaire respondent, otherwise we will return the form un-reviewed.'

'Mmm. We don't need to tamper with the impossibility factor of the Ethics Committees, because they're sorted already.'

'Yes — completely impossible to negotiate them.' Isaac pondered for a while. 'There is, however, a problem.'

'And what's that? Not fiendish enough? Not enough incomprehensible jargon? Or are you worried that patient care might suffer — no, you can't have gone that soft?'

'No. I'm worried,' worried Isaac, 'that we'll do it so well that even we won't be able to do research. Then how will I get my knighthood?'

'But don't you see, that's the whole beauty of the Research Governance ... em ... I know ... Framework. We won't have to. We'll be too busy building systems to monitor the researchers, interviewing them, and writing up our findings. In fact, these will be the only research-related publications to make it. We will be Professor and Mr Research locally, our powerbase will be assured, and your peerage will be in the bag.'

'I see. So the only research,' said Isaac, 'will be on the researchers. I've got a name for it, for my first paper.'

'And what's that, Professor?'

'It's my Theory of Relativity. Because all research from now on will be only be done in theory, relatively speaking!'

'And, in theory, your relationship with the Chief Medical Officer will flourish. Let's celebrate with a drink.'

And so, it was black coffees all round.

Meanwhile, in a far-off land, Dr JKK Rowlkein switched on a computer, logged into Medline, and typed in some search terms …

# Postcard 5 ... Blogging

SCIENCE can seem a dubious activity. It may have made *Private Eye's* Pseuds Corner,[1] but I had some sympathy with the remark that: 'everywhere I have been this summer, I've met people whose professed aim in life is to try to find a way out of the conceptual crisis created by postmodernism'.

Once, when I was still working at the *BMJ*, I went for lunch with one of the editorial registrars and expressed the view that science was merely one mode of discourse competing with others. It seemed like heresy to say it at the time. But then it also sometimes made me a little sad to sit in an editorial meeting and hear 'We must have more science this week!' as though it were a commodity purveyed like soap powder by obliging chaps in white coats.

For example, health stories about alcohol are often in the news. Assigned to investigate, the keen young doctor–journalist rings first the Portman Group, based in Guinness HQ, then the Institute of Alcohol Studies, based in National Temperance House. Their quotes, and the publication of the report to which the story is pegged compose 'the story.' As our own Paul Hodgkin says, 'To the postmodernist the question is whose 'evidence' is this anyway and whose interests does it promote?'[2]

Old school modernists may retort that the message of science can be distorted when it hits the public domain. But they cannot complain about it too much: publication is an integral part of the process. So then there is only doing that thing (publishing) well, or less well.

Apart from a postmodern view, the other blade I pull often from my intellectual Swiss army knife is the notion of an 'attention economy.' It's a fine phrase and ought to have a whole army of Kuhnian normals buzzing over it constructing mental meccano. Instead there is a single provocative article by Goldhaber,[3] and a Harvard Business School book by Davenport and Beck.[4] These two business academics, who presumably grew tired of waiting for Goldhaber to write up, wrote their own instead. Respectable backing for exploitation of such a phrase at cocktail parties does not come cheap!

But in any case, ideas that are interesting enough to talk about at cocktail parties are probably, when all is said and done, more influential. So the process by which ideas reach the public domain is obviously of crucial importance.

But what of the public? In humans, sensory data competes for our attention continually, a process, in neurobiological terms, mediated by the thalamus. The *BMJ* is — par excellence — a place where it is possible to get up close and personal with the processes by which medical information reaches the public domain. It is upscale attention direction for doctors: a thalamus of the body politic of doctors if you will.

But now the internet has happened. So now there is no reason why anyone, anywhere, cannot publish their ideas. And although the obsession with the maintenance of continuity of expression — culture if you like — is not going away any time soon, neither do we face the problem of scarcity of media; only scarcity of attention.

The only attentional problem that really concerns me is my own. So what to do? Well, I have decided to become an artist. Writing it here, in an article, seems glib and superficial, but there is something that science cannot reach, and we badly need it.

The lifestyle, for example. Sir James Mackenzie, erstwhile GP and discoverer of the JVP, did morning surgery before retreating to his shed and the delicate traces his clockwork apparatus made upon smoke stained drums. Sometimes he was interrupted on a call that was literally a matter of life and death; but his presumption must have been for the opportunity of sustained, peaceful contemplation of the mysteries of the body each and every afternoon, after a good lunch naturally.[5]

I want the same space to produce effective rhetoric in the miasma of information that swirls over us all. Just as the first movie cameras were fixed to record the action on a proscenium stage — hardly taking full advantage of the new medium — so we are at the outset of the networked computer revolution. And the tool that holds most promise for me is a weblog, or blog.

So I've been standing in four or five sessions a week for partners on sabbatical or maternity leave in slightly larger practices with a reasonably relaxed pace of life. It's been a solution my own 'peanut butter and jelly problem';[6] starving can blunt an artist's performance.

At the same time, artists need freedom to follow their motivation, in order that it can be captured in their work. Artists understand the craft processes needed for mastery of the distribution of the fruits of their labours. Their job — if you like the word — is to embody concepts for subsequent public transmission. Apart from that, there is merely the struggle to live an authentic life, and reflect on it in a way that is meaningful for others.

My craft has led me not only into software, but cycling and music too. Geeks like networks because they help to build better networks. They help make better music. They help all kinds of things. At the network's heart: taking pleasure and profit from recursive bootstrapping ever-developing

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systems in an economical and entertaining manner. Applications in other domains soon follow. We are moving into a world of information that is person-centred not publication-centred.

We know from survey data of doctors' information-seeking habits that the average consultation in general practice generates at least one unanswered question; and that most are never answered. Those that are most imperative to answer are usually addressed by discussion with a colleague rather than reference to published materials.[7]

Traditionally, what we have had in medical publishing is long boring speeches; what we want and need is conversation. It is true that proactively investigating the world is a resource-intensive activity, but if you can smoothly integrate global communication with one's day-to-day activities using a blog, it can be fairly economical. I am perhaps fortunate that the intermittent production of pithy hypertext paragraphs is an activity that I find satisfying and congenial. Sometimes it can seem altogether egotistical.

But we also know that there is more published information in any one specialty than any individual can possibly hope to master in a lifetime: and yet somehow we have got to keep the show on the road (and we do). Librarians have known this for a long time: it's called 'current awareness', and it is the sine qua non of the generalist.

And that's one way I use my blog: if I answer a question to which I previously didn't know the answer, I write a short paragraph with a link to the materials that were most helpful. Google combs over it a week or two later and increments the importance score of the information I have linked to. That information is more likely to be found in future. In other words, a blog is a convenient way of implementing beneficial patterns in the internet's link density.

It doesn't just have to be question-based either: most GP's consulting rooms have a pin board crammed with guidelines, notices of novel services, normal values and other aides memoire. Most of these documents also exist in digital form: your blog offers another way of storing and organising it, providing a big bucket with automated indexing and stable URLs for files you want to keep handy.

Once someone, somewhere in the world, has blogged something once, all anyone else needs to do is make a link to it. More important documents will be linked more frequently; but even the most obscure information can be there when it is needed. You could do it too. That way, we'll continue to make progress.

**Douglas Carnall**

A weblog or blog is a browser-based user interface that simplifies the task of continually updating a website. The content and variety of blogs are as diverse as the internet itself. Some examples:

http://www.bloviate.blogspot.com/
public health and baseball fanaticism in equal measure.
http://www.ama-assn.org/sci-pubs/amnews/pick_03/bisa0428.htm
US article discussing the ins and outs of medical blogging, with links aplenty.
http://navarino.net:8080/blog
my own adventures in medicine, cycling, music and the internet.

My weblog runs entirely on free software. It is served on an old Pentium machine hooked up to ADSL that lives in the cupboard under the stairs in my house. The basic design ('Squishdot') is based on Slashdot, a popular news and comment site for geeks, whose source code is also freely available. Squishdot is based on Zope, a web application development environment that runs on the GNU/Linux or Microsoft Windows operating systems.

My vision is of many doctors setting up their own weblogs primarily as their own personal CME tool. Besides contributing more content and links to the internet, content entered in a weblog can also be syndicated in summary form on other blogs.

**Douglas Carnall**

## From anthropomorphic to computeromorphic … or, are Furbies alive?

Machines have always made us a little mad. Ships are female and many people — literally — die for their cars. But the enthralling world behind the screen increasingly seduces us because of the emotional hooks and tags built into software.

Using the human brain as the template for advanced software means learning how to model emotions as much as logic. Unable to conquer artificial intelligence by frontal assault the massed ranks of geeks are morphing into neurobiologists and evolutionary psychologists. So now we are seeing 'affective computing devices' — robotic pets, wearable computers and software avatars that exist only in cyberspace. And even before such exotica hit the market a new self-psychology is being called into being. What does it mean to feel bereft of one's mobile phone? To feel naked without e-mail connection? To feel the need to share one's private reflections in a blog open to the whole net? Over dependency may be bad between people, but we don't give it a second thought with computers.

Sherry Turkle, one of the great explorers of the psychodynamics of computers, asked children whether they thought their toy Furby was alive.[1] Ron, aged 6 years, replied: 'Well the Furby is alive for a Furby. And you know something this smart should have arms. It might want to pick something up or to hug me.' Very sophisticated, and not so very different from the GP talking with Candid in *The Inner Computation* on pages 900–901 in this issue.

We seem incapable of not imbuing complex machines with human attributes. But the traffic is two-way. Increasingly we see our heads as machines too — software running on wetware rather than hardware. As Turkle points out for Freudians, using the word 'shut' when you actually mean 'open' indicates ambivalence and conflict. But in terms of processing information it just comes down to a difference in sign: 'closed' is equivalent to 'minus open'. So you had a cranial power surge? So the sign got flipped? Tough luck for Balint fans, but otherwise no big deal.

**Paul Hodgkin**

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dThis is Ray Kurzweil's website and is itself a fascinating, somewhat terrifying tour of far-out thinking on artificial intelligence by one of the world's leading exponents.

**Sixth WONCA Rural Health Conference in Santiago de Compostela**
24–27 September 2003
Santiago de Compostela, Spain

THE sixth World Rural Health Congress was held in Santiago de Compostela, Spain 24–27 September 2003 on the theme: *Rural health in a changing world* and attracted 600 delegates form all over the world. It was followed by a 3-day post conference programme in Braga and Geres, northern Portugal, hosted by the Portuguese Association of General Practitioners, where delegates discussed Miguel Torga, rurality in Portugal, visited health centres and a new medical school at Minho. A selection of postcards from Santiago follow below:

Santiago the city, but why the choice
Of all the cities in the land of Spain?
The voice within was quick to answer
Santiago is derived from the word for health
In French we say 'sante' for health
So none in Spain is better a choice
Than Santiago the city with serene environs

Like a bird in the air I flew for hours
At last I saw with infinite pleasure
The beauty and serenity of Santiago
Conducive enough for all brainstorming
'Health for All our Rural People'
Is now a task that must be accomplished

Since health is a state
Involving the physical, mental and social
Lest all work and no play
Makes WONCA 2003 a dull one,
New Zealanders please come and show
The rich culture of your country

Then a voice from Spain was heard aloud
We first of all must take the turn
As hosts from Galcia, home for all
With lots of music, fruit of the soul
In Spain we have in great abundance
Some bit of it will come your way
Extend your muscle and flex some others
Move your waist and body as well
Dance to the tune the Spanish way

***Ani' Etokidem*** **(Nigeria)**

There's something odd about arriving at the former edge of the known world by plane, but the thought evaporates: our civilisation long ago opted to move faster than the speed of thinking on your feet. As it happened, the sixth WONCA Rural Health Conference in the imposing Palacio de Congresos de Galicia was right on the pilgrim trail, a few kilometres outside Santiago de Compostela. *Rural health in a changing world* was the official theme; as part of the conference's cultural fringe, skilfully organised by John Gillies, I was there to expound 'a cultural history of walking'. Well, doctors started out as a peripatetic profession, so it wasn't a bad subject to address. Walking is intellectual trespass, I suggested, a way of uncoupling thought from production values. But as I walked back to the spires of the city myself, mingling with the surprising number of pilgrims, drop-outs and 'liminars' who had shed their normal lives for a few months to be able to walk to Santiago from Geneva or Berlin or Paris, it struck me that for this type of walker, however secular, the harder the walk the better. Pilgrimage is as much about the materiality of the world as it is about uplift. To walk to Santiago is to earn the right to arrive there. And if grace fails to descend in the famous cathedral, phantasmagoria will get you.

***Iain Bamforth*** **(France)**

This was one pilgrimage to Santiago which was light on penance, (except for the hangovers), but heavy on surrealism. You never knew when you were going to bump into exquisite Spanish bagpipe playing or heart-rending Scottish ballads, or a surfeit of wonderful Galician cuisine. One minute emotionally tossed between the dilemmas of child labour and the despair of AIDS in Africa, the next uplifted into the mystical world of Laplander Else. The audience was mesmerised by the slow unfolding of a life history, tenderly filmed by Eivind Merok, her GP. It showed one woman's simple, trusting, relationship with nature and her animals, controlled by the unforgiving Arctic seasons. Watching this film was as much a religious experience as any pilgrimage.

***Dorothy Logie*** **(England)**

***WONCA — con Fuego***

We came to Santiago as pilgrims
no hat, no staff, our boots less stout
but no less sure

And found — what?
Healing? Music? Passion?
All of these — and more — Galician fire

Kindled, cheers the soul:
a generous tune
tendered to a brighter world

***Anne MacLeod*** **(Scotland)**

As the WONCA link on the organising committee, I had been thrilled with the number and quality of the abstracts submitted, but frustrated over the 'cultural' problems that beset the group and the slow rate of registrations. However, all was forgiven and replaced with sheer excitement as I emerged from a forenoon session to the sound of the international music group organised by John Gillies. The foyer was packed with many of the 580 delegates who had come from 33 countries and, there, striding through the hall were the burly, kilted BASICS team from Scotland. 'Hands on' sessions have always been a feature of our meetings. With so many sessions and my own involvement in chairing and speaking it was impossible to get round many, but the greatest enthusiasm I encountered, was for the work-shop run by Richard Smith (Editor, *BMJ*). Feeds were immense and fascinating… Percebes (goose barnacles)… previously only seen on logs floating into our island shore were a delicious though expensive feast. The second phase, in Portugal, enabled further knowledge sharing, but the real excitement was meeting Dr Fernando Valle, aged 103 years old, who came along to contribute at Iain Bamforth's talk on his old friend Dr Miguel Torga.

***John MacLeod*** **(Scotland)**

No one can prepare you for the workload associated with organising the scientific programme for a WONCA World conference. More than 18 months of hard work contained both the worst of times and the best of times! What a delight it was to see all our hard work coming to fruition and the conference delegates interacting and buzzing with excitement. Santiago was one of the first WONCA conferences to be conducted in a bilingual format. Plenaries and debate forums were simultaneously translated in the main auditorium while English and Spanish language programmes ran in parallel. The workshops and seminars dealt with a range of issues reflecting the problems associated with delivering care and maintaining wellbeing in rural areas around the world. The quality of abstracts received was excellent and as a result, we decided that all the accepted papers should be given the opportunity of giving full oral paper presentations or 5 minute oral posters (where the author displays a traditional poster but also has 5 minutes to describe their poster with only two slides). We believe that this innovative programme achieved the intended goals by building networks, sharing ideas, stimulating debate and building networks. The main conference theme was *Rural health in a changing world* and the conference reflected the threats to rural communities in the developing and developed world. It is surprising how, despite the wide variations in wealth, demography, and geography, that the principles and values of rural practice remain the same throughout the world. Finally, it was disturbing to reflect on whether that special relationship between the practitioner and their community will be retained in the UK (the birthplace of general practice) as we implement the new GP contract. Clearly food for thought!

***John Wynn Jones*** **(Wales)**

Rural doctors' conferences have a special fire — it might be the isolation, the local brews or the need for innovation but whatever it is, the conference this year in Santiago was abuzz with ideas. The farmer's gate would be a good emblem for the rural doctors — no matter how sparse the resources, farmers the world round produce a gate from the local materials to suit the local surrounds. Many can appear bizarre to the foreign eye but they are all functional. The conference in Santiago showcased the farmer's gate equivalents in the health field. The struggle for many developing nations especially under the burden of AIDs was evident, but they still were able to proudly cite the role for rural doctors in making a difference. The interest of the WONCA President Michael Boland in staying for the whole conference and his commitment to taking forward an Action Plan for 'Health for All Rural People' to WHO was appreciated. The Scots showed their independent attitude under self-rule with their own pre-hospital emergency course, indigenous Australians further improved the Kuching Statement on the health of indigenous people and the Norwegians lead a wonderful session on the unique aspects of Rural Medicine. The Spanish and Portuguese colleges' hospitality was immense and the Portuguese satellite conference allowed a first-hand look at rural health clinics. The pilgrimage of so many rural doctors to the ancient destination of Santiago de Compestella had rich rewards for our souls in so many ways.

***Bruce Chater*** **(Australia)**

Striking insights, interesting facts, spectacular boredom. Most conferences offer something in all three categories, and this one was no exception, although I think that they had much more in the first two categories than the last. At a meeting on Miguel Torga, Portuguese writer and doctor, in Portugal, we met Dr Fernando Valle, friend of Torga and retired GP, who was 103 years old on 30 July. He was asked how he had managed to live so long:

*'First of all, I gave up smoking when I was 80 years old, which is important. Also I am hopeful about the future. Why? Because young people will make the world better. And because women are taking more to do with the running of the world, which is a good thing.'*

A founder of the Portuguese Socialist Party, Valle played a major role in uniting the nation after the death of the dictator, Salazar. It is very moving to hear someone who has lived so long, and through so much, show such belief in humanity. Hope, as Heaney says,really is a state of the soul.

***John Gillies*** **(Scotland)**

## Gregynog 2003 — A conference for rural doctors

October 1-3, 2003
Gregynog, near Newtown, Powys

THIS 3-day conference for rural doctors was the fourteenth to be arranged by Montgomeryshire Medical Society in the stately home of Gregynog, as an integral part of Rural Health Week. The black and white hall, which has a long history of artistic endeavour and learning, is surrounded by extensive gardens and the tranquil beauty of the rolling hills of mid Wales.

The original and continuing concept of the conference is the organisation of relevant education for rural doctors by rural doctors. Committee members, who are partners in local practices, organise one session each, which is chosen to complement sessions from previous conferences and address current developments, both clinical and organisational. Excellent standards of presentation from all our speakers have made it difficult to select highlights. Consideration of the 'new contract' was mandatory and thus, this was the first session on the programme covering the organisational aspects and local medical committee view. The morning was concluded with a question and answer session with Dr Peter Holden, British Medical Association General Practitioners Committee negotiator, in his inimitable style. Our belief that we have much to do was reinforced!

Female health filled the afternoon, looking at young people and contraception, breast screening and finishing with current thoughts on hormone replacement therapy and the menopause. We considered aspects of ageing and emergency care on the second day, the highlights being presentations from active BASICS doctors and the day finished with immediate care skill stations including paediatric emergency care. The first session on day three was titled 'The environment — changing patterns in rural communities' and included risks at work, (for example, zoonoses), in the air and water supplies. We have many poor quality private water sources in the countryside. Finishing with a flourish, we looked at our joint of the year, the hip. A master class in examination was followed by an update on total hip replacement. Our hip expert was Mr Patrick Gregson of Oswestry Orthopaedic Hospital.

Dr Malcolm Russell of Hereford won The Gregynog Prize for a photograph of 'Me and my hobby' with his shot of ski mountaineering in Norway. Other supporting events included go-karting, croquet and a buskers evening. Local wildlife expert Diarmid Doody was our after dinner speaker, showing stunning recent footage including red kites and dolphins.

Next year's conference will be held from 28 September to 1 October. We hope to see you there!

**Martin Green**

**The Tip of my Tongue**
**Robert Crawford**
Jonathan Cape 2003,
PB, 51pp, £8 00, 0 224 06968 3

IN 1921, Wittgenstein declared that 'what can be said at all can be said clearly, and what we cannot talk about we must pass over in silence ...'[1] This suggestion (subsequently recanted) inspired a generation of British philosophers to invest its considerable intellect in linguistic analysis, whose objective was to express concepts in precise, unambiguous words. Thoughts that could not be thus expressed were discarded as meaningless: not worth pursuing. As a shameful result, while their continental colleagues were forging historical inroads towards the nature and meaning of life, art and science, British philosophers were sitting around oaken college refectory tables attempting to distinguish between tools and utensils, or collections and assemblages.[2]

Urbach's response to Wittgenstein's early declaration was that 'it is only here that speaking becomes worthwhile.'[3] One of the great functions of art is to express that which is otherwise inexpressible. Poetry is an important vehicle for this function, and Robert Crawford one of its most skilled contemporary exponents, who writes, as the second poem in this collection, *Credo*, argues 'since what we cannot speak about we must'. The title of the collection expresses much of what both poetry and Crawford are about. A great poet inverts your world with a simple phrase, which may itself be a simple inversion, and leaves us gasping, 'I wish I had said that'. The same *Credo* commits to his wife his 'declaration of dependence', and in *Tree Dance* he danders 'fro and to, there and here'.

These poems say a little that had to be said, some that ought to be said, much that is better said, and a certain amount that I would have said, had I Crawford's tongue upon the tip of which to balance my vocabulary.

For it is vocabulary that is this book's main theme. Other themes are important, and would probably be identified by the author, as they were by the publisher. Crawford delivers a deeply spiritual digestion of life and love, of Scotland and the world, of family and society. He adopts convincingly the dual outlooks of Scottish patriotism and internationalism (or even 'planetism'). He conveys the frustrations and the beauties of life in eastern Scotland. He enjoys life, laughs with and at it and sees through it, yet revels in it. Across an apocalyptic Edinburgh sky, he regards not the 'headsetted tourists … Cyborgs on the Castle ramparts' but only his young daughter 'yell a pirouette' before the famous gun, and 'laughing in the cannon's mouth'. In *The Workman* he depicts a council worker painstakingly re-painting the musical names of Fife villages on a series of age-old milestones; these names become the poetry of Fife, which is perpetuated, or even created by this fluorescent jacketed worker; in Scots he may have been called a makar, also the word for a poet. (Auchtermuchty was not included in the litany). In *Uist*, he notices 'behind a croft/ native, cross-bred Hebridean sheep/ scratch themselves on a satellite dish'. I loved, too, his portrayal of giant windmills, whose presence has often moved me to a humble desire to express something inexpressible. An awe-struck meeting of the creativity of humans and spirit is effected in *Windfarming*, where these 'propellor-driven crosses of the risen Christ' are ' totempoled', and stand as 'great ghosts of standing stones

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## Another Postcard...

From ***The Guardian***, *2 October 2003*

'One last thing. I have received, from the director of the Society of Homeopaths, what is possibly the longest letter ever written to any newspaper on any subject. How any alternative therapist who has ever read a newspaper in Britain could possibly claim that they get a bad deal, considering that dark ages superstition has now become the contractually-enforced journalistic norm, baffles me, but in the spirit in which this epic letter was clearly intended I present it here diluted one part in one hundred thousand, in the vain hope that it has more impact on you than it does on me: 'Placeb ...'
Please send your bad science to: **bad.science@guardian.co.uk**'

And from ***The Guardian***, *4 October 2003*

Emma (in-house 'natural health therapist') on molluscum contagiosum — 'the form of treatment that seems to be most successful is homeopathy. You will find it is a very gentle and effective form of natural medicine for all aspects of children's health.
**Society of Homeopaths... http://www.homeopathy-soh.org/**

**Alec Logan**

… piloting the earth on its way'. I wish, 'as has been said before', I had said that!

Yet all of this is secondary to his primary production, the display of languages' riches. Every poem, every stanza, displays shining jewels of our tongues. These are plural because they include English, Scots, and Gaelic primarily, and also Latin and Greek among others. New words, old words, lost words, found words. A true understanding of Crawford's poetry might require a detailed dictionary, and yet does not, for the context and music of the words generally convey their sense (if not their meaning). He defies Wittgenstein's argument (above) by showing us that not only can the inexpressible be expressed, but that a single word usually suffices, and I love this. Whole poems are devoted to this theme (*Croy. Ee. Gaw. Lonker. Pit.*, to name but one!), and others celebrate words like 'patagium' and 'ramgunshoch'. Even when the poem ostensibly has another theme, it is the vocabulary that shines through, almost to the point of distraction (and sometimes, unfortunately, beyond). It is as if his task is to distill images to single words, and that sometimes the images are so rich that the quality of the words has to match. The words, or their selection and sculpture, are creations in themselves. They also sculpt and define the bigger picture. In *The Bad Shepherd*, a commentary on the foot and mouth furnace, he notes 'hairst hogs, maillies, and crocks./ Cloned palls over Cumbria. Shadows over Lockerbire's drumlins. Cling, braxy, scrapie, tremmlin, pindling, all diseases of sheep …': ugliness to which my tongue could never put tip.

Occasional moments of pedestrianism and cliché can be forgiven, I suppose, as in *Aberdeen* where he repeats old jokes and seems to miss the point. Less easy, though, for a layman such as me to forgive, or circumvent is the inaccessibility of some of the writing. I love words, poetry, Scotland and the world, yet some of this passed me by. Who, then, is it for? I presume that I am not sufficiently educated or perceptive enough, and it may be that some of the more obscure members of the portfolio will prove to be important in their own right. However, sometimes (such as in *Emily Carr*) it seems that, in expressing the inexpressible, Crawford is doing so only for the benefit of a select, private, academic audience, such as himself. This is a shame, for the magnificence of the successful poems loses some if its shine in this obscurity. Those without a working knowledge of Scots will find this light even darker. *Fiat Lux.*

**Blair Smith**

**Supervision and Support in Primary Care**
**Eds. Jonathan Burton and John Launer**
Radcliffe Medical Press, 2003
PB, 176 pp £24.95, 1 85775 951 6

Do you remember the scene in the first Harry Potter film where Harry and his adoptive family are whipped by a whirlwind of letters inviting Harry to join Hogwart's School of Witchcraft and Wizardry? The occupants of the house duck and dive unsure where the next message will come from.

It feels the same in that other parallel universe — general practice. The whirlwind of professional development and accountability throws us reflective practice, PDPs, appraisal, revalidation, PUNS, DENS, evidence-based medicine, narrative-based medicine (NBM), medicine-based medicine — ok, I made the last one up. We duck and dive, pull an initiative from the air, toss it back, grab another.

What is missing is a way of helping the individual practitioner make sense of it all; a way of pulling down those great ideas and fixing them to his or her daily practice — transforming an aspiration of 'something I should do' to an action of 'something I will become'.

The authors of *Supervision and Support in Primary Care* argue that the process of clinical supervision can fulfil this role. 'supervision' is a brave word to use in the title of a book aimed at GPs. The authors recognise the strong emotion the term can provoke, with its connotations of management, control and judgement. However, they stick with the word because, away from the culture of general practice in areas such as nursing, mental health and psychology, it is a term with a clear meaning, a strong history, and a robust research base.

It helps to forget the 'S' word. Think instead of what the process aims to deliver: professional enhancement, facilitated learning, learning from experience, the development of a learning relationship. Sounds better already. The authors make the case that clinical supervision is about 'looking after people, rather than looking over their shoulders'. It is about facilitating learning in relation to live practical issues through the formation of a learning relationship with a colleague. The authors hope that clinical supervision will amplify what primary care already does and build on the tradition of informal and formal case discussion over coffee and in corridors and in team meetings and tutorials.

The authors argue that in primary care such a package of supervision and support will not only enhance the individual, but will also provide a mechanism that is 'potentially more effective than external assessment in raising and maintaining professional standards and in protecting the public'. Clinical supervision is both formative in that it facilitates the individual's personal and professional development, and normative in that it provides for the discussion of and movement towards quality standards. (Good things come in threes and so clinical supervision can also be restorative by offering individuals support in the difficulties they experience.)

The book describes several models of supervision, from the traditional one-to-one supervision used in mental health and nursing, to initiatives already familiar to some GPs; such as, Balint groups, mentoring, co-tutoring, and peer supervision groups. The guru of NBM in general practice, John Launer, adds a thoughtful chapter on how the principles of a narrative approach can be used within the supervision relationship. He argues that supervision provides the chance for the clinician to reflect on the story-making process of the GP–patient consultation and that by holding a conversation with another person the practitioner can be helped to transform a story about a working encounter.

I like the work of John Launer. He always writes with vision, clarity and humanity while managing to remain grounded in the reality of life as a GP. I found his final chapter of the book, *Educational supervision in GP vocational training*, particularly stimulating. It offers a way forward to trainers like me who sometimes struggle with the many roles that they are expected to play: educator, assessor, clinician, employer, mentor and counsellor. To Launer, clinical supervision is the fundamental process and these other roles are best seen as adjustments or necessary diversions to this core training context.

I think this is an important book. It describes a practical vision of how the reflective conversation of individual practitioners can be nurtured so as to benefit not only themselves but also their colleagues, their teams, and ultimately their patients and society. My only worry is that the green shoots encouraged by a book like this may get trampled by the heavy feet of revalidation.

**Antonio Munno**

**Stiff — the curious lives of human cadavers**
**Mary Roach**
W W Norton & Company, 2003
HB, 224 pp 0-393-05093-9

I'VE suddenly developed an interest in anatomy, or let me be more specific, forensic anatomy. I'm not sure why or how, although my recent experiences in general practice have, unfortunately, pointed me in that general direction. At the beginning of this summer I was called to see a 32-year-old man who was, literally, breathing his last, although I didn't know this at the time. It was a strange call from the live-in girlfriend of the young man saying he had had a bad cold but his chest was now affected. Fairly innocuous-sounding I thought. I thus took my time, having completed the work of the day. When I arrived he was in extremis, centrally cyanosed, the sweat literally dropping off him, his pulse thready and weak. My attempt to get him hospitalised in time was to no avail. Coroner's case 1.

Six weeks later I was called to another house, where an old patient of the practice had died at least 2 weeks before. With the outside temperature approaching the high 80s, the smell was overwhelming and I really felt sick and ill being there. Seeing the body, or seeing the blackened hands, was more than sufficient before I leapt downstairs and out into the midday sun. Thankfully she was face down but I couldn't wait to get out. The policeman outside, guarding the door as if she was about to escape, obviously knew I hadn't come across this too often ('do you know what you do next?' he asked). Coroner's case 2.

This brings me to Mary Roach's off-putting, delicious, well-written, but ultimately grotesque book on what cadavers get up to in the hands of modern men. It is a wonderful read. While some of it is historical, a lot of it is straight anatomy and some of it is just downright weird. The chapter on the culinary delights of eating bodies is amusing, daft, odd and will certainly put you off parts of China for good. I loved it.

Mary Roach tells us early on that she is a tad unusual in that her first cadaver study was her mother's ('the cadaver that was my mother. My mom was never a cadaver; no person ever is'). Apparently, those around her found the subject repugnant, as illustrated by library assistants giving her more than quizzical looks. Her family and friends were also more than reluctant to talk about the subjects of her work, clearly marking her off as someone odd and strange.

Leaving bodies out in multiple environments to specifically look at decomposition (Chapter 3) helps our forensic colleagues, while the army want cadavers for data related to what else, but impact, tissue injury and ballistics (Chapter 6). Experiments involving cruxification appear in Chapter 7, and the now clearly insane experiments done on head transplantation in the last century are described in Chapter 9. Thankfully, some of these cranial exchanges were conducted on dogs, although whether this makes it more acceptable or not I don't know. Interestingly, the famous Dr Kervorkian was responsible for one of these — presumably another reason why he is called Dr Death. The most fascinating chapter is the penultimate where the possible composting of bodies is being mooted in that most green and environmentally-sound of countries, Sweden. Here the process, if it takes off ('takes root'?), will be about freezing bodies before mulching and laying out in the garden where it will take on average, 6–8 weeks. According to the protagonist, lots of people are interested in it and are desperate for it to begin.

Inevitably, our old friend, Dr Gunther von Hagens, appears towards the end, with the plastination process in units that do this type of thing in the US.

I have to recommend the book purely for its historical gaze, its sheer delight in describing the curious lives of human cadavers and, despite what I have said, the author manages to preserve dignity and a certain respect for the cadavers she describes. Should the average general practitioner read it — I don't know, it depends if you've had a summer like mine?

**Surinder Singh**

## On vocation

At school I was never any good at sport. On the rare occasions when my mother, in a cruel access of puritanism, withheld the usual 'off games' note, and the last few shivering ball-bunglers were being allocated to the Skins or the Jerseys for the weekly kick-around, it was always, 'Sir, do we *have* to have Neighbour? We had him *last* time.'

Not that it didn't hurt. So imagine how hopefully my ears pricked up when our GP, Dr Heap, shown the itchy mankiness between my toes, diagnosed athlete's foot. Athlete's? I thought; well it's a start. But it was not to be; after only a few applications of his tincture of gentian violet, the fungus, and with it any dream of sporting prowess, was expunged.

Now there's magic for you — a man who can look at your foot and read your soul, paint the one bright purple and, with the hot poultice of truth, surreptitiously cast out foolish imaginings from the other. I remember wanting to do things like that.

In the sensible days when medical students were selected by interview, tutors for admission were wont to divide candidates into two groups — those who claimed their vocation to become doctors stemmed from reading *Middlemarch*, and the rest. This latter, smaller, set included an implausible few who asserted, road-to-Damascus-style, that it came to them in a blinding flash that their mission in life was to Heal The Sick. Rather more conceded that, having got good grades in science A-levels, it was, like, kind of, inevitable. A few cocky souls boasted that since everybody, or nobody, in their family was a doctor, their destiny was to conform to, or break, the mould. A brave but honest rump, asked why they wanted to be doctors and biting back an unimpressive 'Dunno', struggled to express with acceptable eloquence the simple fact that they hadn't a clue whence sprang their motivation, and that, with respect, the question was a silly one.

I'd have been one of the 'dunno's. Personally, I've always been sceptical that so priggishly evangelical a doctor as George Eliot's Tertius Ludgate could inspire anyone to anything other than the urge to throttle him. (So marrying the mayor's socially ambitious daughter proved his ruin? Serve him right, I say: if he'd spent less time puffing the virtues of scientific progress and more on buffing up his communication skills, he'd have been a happier man.) And I've never had a Damascus road experience, not unless you count the realisation that golf is a silly game. What's more, no one in my family was medical; but I don't recall ever holding that against them, nor feeling any great weight of expectation on my youthful shoulders. I just know I never wanted to do anything else: not for long, anyway. But where does vocation come from?

And indeed, what *is* vocation? To a person untouched by it, I guess to have a vocation seems like something noble, something to be envied, something that saves a whole bunch of trouble at the careers convention. From the inside, isn't it more like this: a sense that one's destiny is in the unseen but reliable hands of some inevitability that whispers life's destination in your ear even as you get under way? The voice that whispers is often indistinct, though in my own case it's Dr Heap's if it's anybody's.

Even so, I can't quite accept that something as banal as the athlete's foot incident was enough reason to embark on a career which, however rewarding in hindsight, was in its early stages often distasteful, exhausting, and seemingly disconnected from the furtherance of human wellbeing.

I don't know — I really don't know — whether there is such a thing as vocation. It's an attractive badge for one's professional motives, and can disguise (if disguise is needed) a host of less laudable gratifications: status, power, money, security, atonement, vicarious intimacy. But one can feel driven without there being a driver. Moreover, it's the car's engine that propels it, not the go-faster stripes emblazoned *post hoc* on its sides. Oh! the unanswered questions. Is vocation after all a mythical beast, like Nessie or the phoenix? Extinct like the dodo, or, like the panda, cuddly but endangered? A parasite like mistletoe, nourished only by the living sap of sturdier rationales? A dream, a false memory, a fictitious invention of the questioned mind?

Whatever. It is certain that something sometimes happens — fortunately — to impel the unsuspecting young towards this most marvellous of jobs. And I wish we knew how to spot it, foster it, select for it. The Scottish educationist AS Neill once pondered, 'If we have to have an exam at 11, let us make it one for humour, sincerity, imagination, character — and where is the examiner who could test such qualities?' And I reply, 'Actually, Mr Neill, probably in the RCGP.'

# Meeting of Council — 12 September 2003

**Audited Accounts for 2002–2003**
This was a significant occasion as this was the last set of accounts to be presented by our Honorary Treasurer, Dr Tony Mathie, who will be completing his term of office in November.

Dr Mathie reflected on his period as Honorary Treasurer and highlighted that when he first took on the role, the College's income was some £3.5 million. This increased to £15.2 million in the last financial year.

Council was informed that the College finances were in a healthy state, with the deficit incurred from the WONCA Conference in 2002 being written-off completely. There was a surplus of £90 000 at the year-end.

**The meaning of Fellowship**
Professor Dame Lesley Southgate, who chairs the Fellowship Committee, introduced a paper following a major review of the Fellowship by Nomination (FbN) procedures. The aim of the review had been to make the Committee's procedures more open and transparent. The Committee had also come to the conclusion that the current percentage of Fellows is too low and needs to be reviewed. They have been considering ways of demonstrating more clearly why a candidate has been awarded FbN. Dame Lesley explained the changes that had already been introduced by instituting a system of reviewing each application before the meeting against agreed criteria.

The paper covered recent developments with FbN, a summary of the purposes of Fellowship and the inequity in nominations for Fellowship among the Faculties. Differing attitudes to FbN among faculties effectively disbarred some members from attaining Fellowship.

The Fellowship Committee proposed that the current percentage of Fellows was too low and that, in the fullness of time, every eligible College Member should be able to be considered for Fellowship. The President also stressed her view that the Fellowship Committee should continue to be the ultimate decision-making body.

Professor Mike Pringle spoke to a motion on a related topic asking that consideration be given to re-establishing a single route to fellowship. The motion read: *The RCGP should consider re-establishing a single route to fellowship.*

The authors of this paper set out why they believe the RCGP should explore the case for establishing a new route to fellowship to replace the two current routes; Fellowship by Nomination and Fellowship by Assessment. They were not asking for a decision to establish such a system — just for Council to approve a study of the implications within an appropriate group to report back within 6 months.

Council discussed the two papers and there were wide-ranging comments and issues raised.

The summary of the discussion was that the issue of Fellowship needs to be addressed. Council gave its support in principle for the proposal put forward by the Fellowship Committee. There was also support for the proposal in the motion for a group to be set up to explore the implications of a single route to Fellowship. The President and Chairman of Council will be considering the representation of the group and it is expected that a report will be made on their deliberations within 6 months.

**RCGP Strategic Plan**
Council had the opportunity to discuss in detail the draft Strategic Plan for the College. This received a good reception and many helpful comments were made. There was a discussion on how the Plan would be disseminated and it was suggested that the overview could be published in *The New Generalist.* It was suggested that the plan should also include reference to clinical governance and the shift from individual care to team-based care. It was also felt that the key aims need to be strengthened. With minor amendments Council supported the Plan.

The next stage will be to include a review timetable for the document and develop an operational plan. It is our intention to publish the plan in the spring of 2004.

**RCGP Position Statement on GP training**
The Chairman of the Education Network, Professor Steve Field presented a paper outlining the principles for the development of GP Training Programmes in the UK. The paper followed on from Council's consideration of the establishment of the Postgraduate Medical Education and Training Board and the Department of Health's plans for modernising medical careers. The paper set out the RCGP position on training that will be used in the College's discussions with the Department of Health. The principles laid down in the paper will also be used as a basis for the RCGP review of the curriculum.

The paper was slightly amended to include a reference to workforce issues where, with the expansion of specialist training, would have an effect on GP training. It was also stressed that the College's standards should not be reduced to meet workforce pressures. The position paper will also now include a reference to the need for flexibility on the requirement for a minimum of 3 years training, to reflect individual needs.

Professor Field will be reporting back on a regular basis on progress with the curriculum review.

**Revalidation and appraisal**
Council received an oral update on developments on revalidation and appraisal from Professor Haslam. He reiterated the College's concerns with the use of the summary of evidence from five annual appraisals being sufficient for revalidation as well as the lack of patient safety issues and quality assurance of the process. He also noted that the Shipman Inquiry has taken a particular interest in the current revalidation proposals.

The Chairman had been invited to meet with the Chief Executive of the GMC where it had been proposed that joint work be undertaken with the GMC to look at clinical

governance and consider how it can helpfully impact on revalidation.

Council's attention was also drawn to the excellent documents produced by RCGP Scotland on revalidation and appraisal which had been circulated to all GPs in Scotland and posted on the Scottish College's website. The Scottish Appraisal Toolkit document was due to be published soon. We are now undertaking work to see how these publications can be adapted for use in England. The potential for adapting these documents for use in Wales and Northern Ireland is also being explored.

**The use of data to improve quality in general practice**
Our Chairman appended to his report a paper on the outcome a seminar that was held at the Nuffield Trust in May. The seminar had been hosted by the RCGP, National Clinical Assessment Authority, Commission for Health Improvement and the National Primary Care Research and Development Centre. The purpose of the seminar was to increase understanding of the work of each agency and their forms of assessment and the collection and use of data.

Springing from this document, Council members raised the whole issue of the increasing demands for data collection on clinicians. This is especially relevant in view of the proposals to establish the Integrated Care Records Service (ICRS). The College will be developing a position statement on data collection, which will be taken forward by CEC in October and a paper will come to the November meeting of Council.

**Cannabis and the general practitioner — *Going to Pot***
Council considered and approved a position statement on the need to define the health risks of cannabis. The paper gained overwhelming approval at Council and will be posted onto the College website shortly as guidance for Members.

**Annual General Meeting**
The Annual General Meeting this year will again be held at the Victoria Park Plaza Hotel on Friday 14 November 2003, commencing at 2.00 p.m. The Notice for the AGM was included with the October issue of the Journal. The meeting as usual will include the presentation of Fellowship and Awards, a lecture by Professor Richard Baker entitled *Clinical Observer: on the up or over the hill?*, as well as formal College business.

**The next meeting of Council**
Saturday 15 November 2003.

**Maureen Baker**

## diary

**1 December 2003**
Oral anticoagulation management training
University of Birmingham
*Contact: Tricia Henley;*
*e-mail: t.henley@bham.ac.uk;*
*Tel: 0121 4158017*

**5 December 2003**
The clinician, the client and the controversies in Breast Care
Edinburgh
*Contact: Maja Maunic;*
*e-mail: breastcare@rcn.org.uk;*
*Tel: 020 7647 3586*

**09 December 2003**
Shipman Inquiry — Controlled drugs in the Community
Sheffield Faculty, Rotherham
*Contact: Marilyn Lidster;*
*e-mail: m.e.lidster@sheffield.ac.uk;*
*Tel: 0114 2715830*

**7 December 2003**
Minor Surgery
North West England Faculty, Chorley
*Contact: Jackie Dartnell;*
*e-mail: nwengland@rcgp.org.uk;*
*Tel: 01925 662351*

**7 January 2004**
Child Health Surveillance
North West England Faculty, Chorley
*Contact: Jackie Dartnell;*
*e-mail: nwengland@rcgp.org.uk;*
*Tel: 01925 662351*

**21 January 2004**
Mental Health Masterclass 2: Training on Mental Health Skills
*RCGP, London*
*Contact: Natalie Hutson;*
*e-mail: nhutson@rcgp.org.uk;*
*Tel: 020 7344 3130*

**26 January 2004**
MRCGP Examination Preparation Course
*Wessex Faculty, University of Portsmouth*
*Contact: Carol White;*
*e-mail: cwhite@rcgp.org.uk;*
*Tel: 01264 355005*

**28 January 2004**
Mental Health (Module 2)
North West England Faculty, Chorley
*Contact: Jackie Dartnell;*
*e-mail: nwengland@rcgp.org.uk;*
*Tel: 01925 662351*

**31 January 2004**
East Anglia Annual Fellows Meeting
East Anglia Faculty, Cambridge
*Contact: Annemarie McCarty;*
*E-mail: jc03@dial.pipex.com;*
*Tel: 01223 884324*

## neville goodman

### Management speak

Now it can be told. The story is now official: Deloitte and Touche concluded (see www.agwsha.nhs.uk) that North Bristol NHS Trust's management (upper echelons now largely replaced) worked in a culture of fear throwing money at government targets. If that was their only failing I would not feel quite as uneasy as I do. The management saw a clash between targets and cash: they could hit (most of) the targets, or they could (almost) balance the books. They made a decision. They (or we) went after the targets and ended up with a large overspend for which they were pilloried. But if they had chosen the other path they (or we) would have missed the targets and still been pilloried. No: I worry less about a rock and a hard place decision than what management in the NHS has become.

It doesn't help to be reading Michael Loughlin's brilliant book, *Ethics, management and mythology* (Oxford: Radcliffe Medical Press, 2002). He makes you realise that management speak is not a sophisticated way of presenting difficult concepts; it is instead a semantically empty zone from which concepts are entirely lacking. Take our previous management's job description for a 'director of organisation development', approximate salary £75 000. After a job summary (development to support the NHS Plan and modernisation of services in Bristol), and a list of the people and departments with whom the post-holder will work, come the nine principle [sic] responsibilities.

Doctors have become used to job descriptions and person specifications, with their lists of essential (MRCP, familiarity with UK health system) and desirable (Nobel Prize winner, not an axe murderer) attributes. While they don't always help differentiate between candidates at least they mostly make sense. But what of the responsibility (number one) to 'work with colleagues to shape the organisational value system and cultural change programme which will define the way services are improved and delivered by the organisation'? While you're working out which tool from your toolbox you need to do that, how about (number two) using 'an evidence-based approach to change by fostering an organisational development and human resource culture of research, learning and innovation'?

I wouldn't trust someone who can write such nonsense to run a sweet shop, let alone the largest NHS Trust in the country. Deloitte and Touche's remit was entirely one of finance, and aspects of management that affected it. I fear that their investigation was merely into a symptom of a more virulent disease.

## our contributors

General practice is still more congenial to **Douglas Carnall** than being a cook, shoeshine, or clerk. Now in pensionless semi-retirement, his cycling, music, and software hobbies spiral out of control.
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**dougie@carnall.org**

**Maureen Baker** is Honorary Secretary of Council for the RCGP.
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**Alan Evans** is senior lecturer in general practice at the Adelaide University Rural Clinical School in South Australia.

**John Gillies** is a GP in Selkirk.

**Martin Green** is a GP in Llanidloes and Caersws in Mid Wales, has been chairman of Montgomeryshire Medical Society for three years. He is chairman of the Welsh Rural Postgraduate Unit and a trustee of the Institute of Rural Health.

**John Sandars** lectures at the School of Primary Care and Evidence for Population Health Unit, University of Manchester.

How to get published in the BJGP? Fly on very low-cost airlines, choose your seat next to the Deputy Editor and engage in idle banter, like **Andrew Sharp** who the rest of the time is a GP in Leicester with miscellaneous interests in health informatics.
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**http://www.visualread.com**

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As does **Blair Smith**, an academic general practitioner from Aberdeen, which leaves plenty of time for writing poetry, owning a Great Dane and serving in the Royal Naval Reserve.
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**Andrew Thornett** is back from Australia and is a senior clinical lecturer in Medical Education at Staffordshire University.
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**Rowena Young** is chief executive of the School for Social Entrepreneurs (**www.sse.org.uk**) and was formerly development director at the Kaleidoscope Project, one of the UK's largest treatment and rehabilitation centres.

## alan munro

### Enlightenment

THE small monastery compound was already full, to bursting it seemed, with hundreds of robed monks, yet a steady stream still squeezed in. Juniper fires flickered around us. Pungent smoke and deep, resonant chanting mingled in the frosty, breath-laden, morning air. In the middle of the compound, under an awning, the principal players in high hats and splendid costumes fussed around their abbot. The chanting built steadily to a reverberant climax. Suddenly, there was silence. For a moment, only the gasping breath of the abbot was audible. Then his limbs and body convulsed in wild movement, restrained by his attendants in a frenzy of activity. An immense, decorative helmet was placed on his head. The spirit of the Protector of Religion had entered his body. In spite of his twisting and leaping, the oracle's insights communicated in words understood only by initiates, were noted by his attendants. Then the writhing ceased, the headdress was whisked away, and in a scrum of solicitude the limp body of the old man was spirited off into the depths of his monastery.

The State oracle of Tibet, the high Lama of Nechung, to this day, advises the Dalai Lama.

In 1950 Tibet was occupied by Chinese communists. America was squaring up to the People's Liberation Army in Taiwan and Korea. Contacts between the CIA and the Tibetans, anticipating war in Tibet, had begun. But, the oracle repeatedly advised the 16-year-old Dalai Lama against confrontation, and was in favour of an attempt to cooperate with the invaders. Probably much Tibetan bloodshed was averted and there was no war between America and China in central Asia.

In Europe, religion was banished from the conduct of secular affairs long ago. In eighteenth century France, devastated by religious wars fuelled by the intolerance of the counter reformation and the barbarous excesses of the Inquisitions, the Philosophes reserved for organised religion the most lacerating of their wit and irony.

D' Holbach, in the *Encyclopedie's* entry on priests, wrote: 'People became accustomed to regarding them as favourites of the gods … The priests knew how to make profitable the high opinion which they cultivated … To establish their empire more securely they painted the gods as cruel, vindictive and implacable … Human blood flowed in torrents on the altars … The priesthood, elated with its power, disputed the rights of royalty … To resist them was a revolt against heaven … was to sap the foundations of religion … Such were the degrees by which the priests of paganism raised their power … In spite of the obedience and kindness advised in the Gospel, … we have seen some priests of the God of peace raise the standard of revolt, arm the hands of subjects against their sovereigns … claim for themselves independence of the laws. In countries where the hideous Inquisition was established it furnished frequent examples of human sacrifices in no way inferior to the barbarism of the Mexican priests.'

Voltaire referred to the church simply as 'l' Infame'.

Diderot, on political authority: 'Power that comes from the consent of the people necessarily presupposes certain conditions that make its use legitimate, useful to society … that it be done with reason and proportion …'

Thus, in Britain in the twenty-first century, democratic and free beyond the even the dreams of Philosophes, a leader who subscribes to the superstitions of the Inquisitors, who relishes intensity of hierarchy, who believes that righteousness is not determined by wide consultation, but is glimpsed by a man privately in communion with his God and priest, who is surrounded by sycophants wholly dependant on himself for their positions, and who takes the country to war against the wish of the majority relying on the counsels of one mad, manic, irascible acolyte; such a thing is of course impossible, inconceivable.

Buddhism glorifies the middle path. To have known where it might lie in occupied Tibet, I wonder if the old abbot of Nechung took good care to consult widely. I like to think so. (It is recorded that the abbots of at least some of the other great monasteries — Drepung, Sera and Ganden — also opposed confrontation). I wonder too if it is mere linguistic coincidence that the aspirations of the Philosophes and of Buddhists coalesce around just one word: Enlightenment. But of course, that is a poor, feeble thing compared to being right.

**Bibliography**
Avedon J. *In exile from the land of snows.* London: Wisdom, 1985.
There is an Open University Course entitled The Enlightenment (A206). For further information visit: http://www3.open.ac.uk/courses/bin/p12.dll?C01A206.