The Back Pages

viewpoint

The space of our lives

THE huge success of biomedical science is predicated on the study of the individual as a generalised unit of humanity. By ignoring the particular, science elucidates what humans hold in common either as a whole, or when gathered into groups bearing diagnostic labels. The political doctrine of utilitarianism cultivates a similar blindness in its honourable pursuit of the greatest good of the greatest number.[1] Within the new GP contract we see these two forces of science and politics coming together in a reductive double blindness that treats all doctors and all patients as replaceable units within a vast machine of health care that is expected to become more efficient and effective with each year that passes.

Clinicians in daily contact with the unique particularities of a succession of intensely individual patients are painfully aware of the weakness, indeed the absurdity, of this double blindness. Over recent years, clinicians, and perhaps in particular general practitioners have sought to re-emphasise the importance and wonder of the unique human person through attention to individual biography and the power of narrative to create meaning, dignity and coherence, each of which are constitutive of health. So far so good, but on page 72 Hyla Holden reminds us in a timely and convincing essay that we may have rediscovered the importance of history, but we still have much to learn from geography.

In *A Fortunate Man*, first published in 1967, John Berger situates the general practitioner within a landscape and Jean Mohr's photos follow him as he moves between and within his patients' homes criss-crossing the community that he shares with them.[2] More than 30 years have passed and today general practitioners do far fewer home visits and often live outside their practice areas. What have we lost? How much does it matter?

Every general practitioner knows that more can be discovered on a single home visit than from a succession of consultations in the surgery. Circumstances, memories and aspirations are all inscribed on a home and tell stories of cohesiveness, displacement or separation. For each patient, the doctor begins to learn about what or who is near or far and about how much pain or pleasure is contained within these distances. The tea towel map of New Zealand pinned to the wall of an old person's kitchen in Kentish Town provides just one tiny example. Yi-Fu Tuan has written about the difference between place and space: the former providing the fixity necessary for security and the latter the opportunity for movement and exploration.[3] From the safety and stability of a known place, each of us is aware of the openness, freedom and threat of space, and vice versa. Each patient seeks their own balance: some cling to the security, however limited, of the known; others take great risks to find new freedom and opportunity in the unknown and begin the tough process of changing strange space into safe place. More people than ever before are moving great distances and across national boundaries, often for pleasure, but too often forced by persecution, war or poverty. This unprecedented level of human movement disconnects people from home and family, fractures the cohesion of community structures and comes with both rewards and costs. As general practitioners, we see both the losers and the beneficiaries.

The perception of both place and space is affected by illness and disability, often with a heightened sense of the security of the one and the threat of the other.[4] Each patient's interaction with the health service is played out through geography. Distance from the surgery or the hospital may be a powerful disincentive to attending, particularly for those who are feeling vulnerable, and especially if they are also dependent on public transport. Where geography intersects with biography a whole family may be left with an enduring fear of a particular hospital that will undermine their ability to use available health services. General practitioners' referral patterns already reflect this detailed understanding of the individual geography of patients.[5] By enriching this understanding as Holden advocates, we are taken deep into the detail of individual lives, witnessing the intertwining of time and space. A patient known in this way can never again be viewed as a generalised unit of this or that diagnosis and the insidious dangers of our new contractual situation will be mitigated.

Iona Heath

1. Nussbaum MC. *Poetic justice: the literary imagination and public life.* Massachusetts: Beacon Press, 1995.
2. Berger J, Mohr J. *A fortunate man: the story of a country doctor.* London: RCGP, 2003.
3. Tuan Y-F. *Space and place: the perspective of experience.* Minneapolis: University of Minnesota Press, 2001.
4. Toombs SK. *The meaning of illness: a phenomenological account of the different perspectives of physician and patient.* Dordrecht: Kluwer Academic Publishers, 1993.
5. Chishty V, Packer C. Age, distance from a hospital, and level of deprivation are influential factors. *BMJ* 1995; **310:** 867.

GPs are not trained in cartography or ethnography; the map-making process is largely unconscious and is therefore private and non-replicable ... (But) this ethnographic and geographical knowledge forms an indispensable part of the GP's equipment.

Hyla Holden on the social geography of general practice, page 72

We understand the symbolic significance of a swastika or a mushroom cloud in a painting, but cannot be expected to know that the presence of a lute in a Dutch genre painting signifies erotic lust.

Benny Sweeney, Postcards, page 70

At the end, when the dead from the final battle are buried at sea, we share their comrades' stoical grief and their conviction that they died in a just cause.

Toby Lipman enthuses, *Master and Commander*, page 76

contents

Meeting of Council — 15 November 2003

Chairman and Officers of Council, Chairs of Networks and Committees
As usual, at the first meeting of the year, Council elected our Chairman and Officers of Council and chairs of committees and networks. Dr Roger Neighbour attended his first Council meeting as President of the College and Dr Colin Hunter took up his new role as Honorary Treasurer. Council also welcomed Dr Mairi Scott to her first meeting as Chair of Scottish Council. Dr Graham Archard was appointed as Chair of Clinical Network and Professor Nigel Mathers as Research Group Chair. We were also pleased to welcome Miss Joy Dale as Chair of the Patient Partnership Group and Dr Kate Adams as one of the two elected GP Registrar Observers on Council.

A number of vacancies for GP representatives have arisen on various College Committees. Some vacancies are only open to Council members, but the Committee on Medical Ethics and the Patient Partnership Group both have vacancies for GP members.

Annual General Meeting — November 2003
We had a very well attended and successful AGM, which was again held at The Victoria Park Plaza Hotel. Eighty-one Fellows were appointed, and Honorary Fellowships awarded. A number of special awards were also made. Professor Dame Lesley Southgate completed her Presidency by handing on the chain of office to Dr Roger Neighbour and presenting her portrait, painted by Christian Furr, to the College.

The main formal business of the meeting approved the proposed updates to the College Bye-laws, which had been circulated before the meeting. Wessex Faculty representatives gave an exciting presentation to promote the 2004 College Spring Symposium to be held in Bournemouth from 23-25 April 2004. For full information and to register for the conference please go to the website at: **www.seachange04.com**. It was agreed that in future the Spring Symposium presentation would be given earlier in the AGM so that all those attending would have the opportunity to see it. Our next general meetings will be held in Bournemouth (as part of the Spring Symposium on 25 April) and the AGM on Friday 12 November 2004.

Budget Strategy 2004-2005
The broad principles of the Honorary Treasurer's budget strategy were agreed by Council. For 2004-2005 a 'roll over' baseline budget (with the exception of locums, per diem payments, staff salaries and expenditure outside the control of the College) will be prepared for consideration by Finance Committee and CEC in January.

Shipman Inquiry
I informed Council about the latest developments regarding the College's involvement in the Shipman Inquiry. The Inquiry has now embarked on the next round of topics for consideration at the seminars and is seeking our comments on some of the various areas that will be covered. I am keen for as many members as possible to have the opportunity to contribute to the College response on the very important issues outlined in the paper *Safeguarding Patients*. The document is available for members to read at: **www.the-shipman-inquiry.org.uk/gencat.asp?p=2&ID=263**

RCGP UK Primary Care Workforce Committee
Council agreed to the formation of a new UK committee to act as an expert group and to provide support to members and others on primary care workforce issues. Nominations for representatives for this committee are now being sought.

Fair for all personal to you: choice, responsiveness and equity
The College's response has been placed on our website and can be found at: **http://www.rcgp.org.uk/rcgp/education/proposals_for_reform_sho_.asp**

Integrated Care Record Service
At the special request of Council, Dr John Williams was invited to speak to this paper and outlined the far reaching implications for GPs of the changes that are planned. Council approved the five points outlined in the summary and together with additional supporting information these will be published on the College website.

Insurance and the general practitioner
Council supported the proposals set out in this paper and the matter will be taken forward through the RCGP/GPC Liaison Committee. Further information will be circulated following this.

Revalidation and appraisal
This paper, prepared by Professor Mike Pringle, initiated a full and wide ranging discussion. The paper is to be revised following comments by Council members and will then go forward to the RCGP/GPC Liaison Committee, and the GMC and will also be submitted to the Shipman Inquiry.

If you would like any further information on the matters discussed above or any other issues we covered at Council, then please do not hesitate to contact me by e-mail via **honsec@rcgp.org.uk** The Council will next meet on 13 February 2004 at Princes Gate.

Maureen Baker

Royal College of General Practitioners

President, Officers and Chairs 2003-2004

President
Dr **Roger Neighbour**
Chairman of Council
Prof **David Haslam**

Vice-Chairman
Dr **Tina Ambury**
Honorary Treasurer
Dr **Colin Hunter**
Honorary Secretary
Dr **Maureen Baker**

Chairman of Scottish Council
Dr **Mairi Scott**
Chairman of Welsh Council
Dr **Mike Jeffries**
Chairman of Northern Ireland Council
Dr **Peter Colvin**

Chairman of Quality
Dr **Has Joshi**
Chairman of Examination Board
Prof **Valerie Wass**
Chairman of Clinical
Dr **Graham Archard**
Chairman of Education
Dr **Steve Field**
Chairman of Research Group
Prof **Nigel Mathers**
Chairman of Communications & Publishing
Dr **Mayur Lakhani**
Chairman of International Committee
Dr **John Howard**
Chairman of Ethics Committee
Dr **Iona Heath**
Chairman of Patient Partnership Group (PPG)
Miss **Joy Dale**

Learning about drug safety on the internet

THE Drug Safety Research Unit (DSRU) is a charitable organisation based in Southampton whose mission is to monitor, study and communicate the safety of medicines. Since 1981 the unit has conducted Prescription-Event Monitoring (PEM) studies of newly-marketed drugs with the aid of voluntary collaboration from thousands of GPs in England.

Increasingly, the DSRU is taking on an educational role and recently it has developed two internet-based educational modules on the safety of medicines that are specifically designed for GPs. Each has been accredited by the Distance Learning Panel of the UK Conference of Postgraduate Advisers in General Practice for 4 hours of continuing professional development.

Professor Saad Shakir, Director of the DSRU, commissioned the development of the modules 'in order to give something back to GPs who have supported PEM by filling in more than one million green forms over the years'. The modules were designed by Dr Patrick Waller, a consultant in pharmacoepidemiology, with the help of several practising GPs.

Within each module there are worked examples and multiple choice questions that test what has been learnt. In order to access the tests, it is necessary to register for accreditation. The DSRU provides feedback on performance by e-mail and certification of completion within 1-2 weeks.

The first module is at 'introductory' level and has the following learning objectives:

- To increase awareness and understanding of adverse drug reactions as an important and potentially preventable cause of disease
- To help GPs use medicines more safely
- To promote understanding of and effective use of safety monitoring schemes
- To provide guidance on where information relating to drug safety may be obtained.

The second module is at 'advanced' level and has the following learning objectives:

- To increase understanding of the mechanisms underlying adverse drug reactions and the factors that predispose patients to them
- To enable a structured approach to critical evaluation of drug safety studies and to increase understanding of the epidemiological methods used
- To develop a structured approach to balancing benefits and risks in the context of discussions with individual patients.

The modules are free to GPs and can be accessed at **www.dsru.org**

flora medica theophrastus bombastus

From the journals, November 2003

***New Eng J Med* Vol 349**
1793 Postmenopausal women with oestrogen-dependent breast cancer now receive 5 years' treatment with tamoxifen, but what then? Usually nothing, but this trial shows better outcomes in the group randomised to follow-on treatment with an aromatase inhibitor, letrozole.
1893 Being a person of CHARM, you will remember the series of papers that compared an ACE inhibitor with an angiotensin receptor blocker in heart failure. VALIANT makes a similar comparison in a high-risk population after myocardial infarction, once again showing equivalence (valsartan/captopril).
1925 A series of 30 patients with Parkinson's disease were totally dependent on carers until 5 years ago, when they had wires implanted to provide sub-thalamic nucleus stimulation. They all improved and remain self-caring.
1936 And that's good news for the carers as well as the patients, because this study of Alzheimer's disease shows that full-time caring is very exhausting.
2004 Very expensive new drugs that modulate the immune response tend to end in 'mab' (monoclonal antibodies) or 'cept' (recombinant human tumour necrosis factor receptor fusion proteins): both can be used to treat psoriasis. Efalizumab and etanercept worked in these studies.
2091 Laryngectomy may soon be a rare operation, following the long-term success of combined chemotherapy and radiotherapy for advanced laryngeal cancer.
2117 Who do you want to do your operation? The chap who's done lots of them — and you're right. The procedure volume for individual surgeons is linked to patient survival.

***Lancet* Vol 362**
1433 'Post-viral wheeze' is a useful term for what often gets misdiagnosed as asthma in pre-school children. Giving prednisolone at the start of the next illness does not seem to help.
1517 Cannabis had little effect on the symptoms of multiple sclerosis, but most patients could tell they were taking it, man.
1527 Which drugs have the best effect on outcomes in hypertension? Any you like, to prevent stroke and coronary disease. But calcium channel blockers increase the risk of heart failure.
1599 For chronic low back pain, there's no need to put a door under the mattress: just use a medium firm mattress.
1689 Get ready to say 'ximelagatran' as often as you say 'warfarin' now: whenever the two have been compared, the newer drug comes out better, and is given at a fixed dose without blood testing. Here it prevents stroke in atrial fibrillation.
1779 It's a worrying discovery that caesarean section doubles the risk of subsequent stillbirth: the only comfort is that it is still only 1 in 1000.

***JAMA* Vol 290**
2271 Carotid intima-media thickness is a strong predictor of later cardiovascular disease: two studies of young people, in Bogalusa, US, and in Finland, show that it is linked to weight (above all) and low density lipoprotein cholesterol. Don't be young and fat and Finnish — it's far better to be thinnish. And the youth of Bogalusa should make efforts to get sprucer.
2428 Treating depression in elderly people with osteoarthritis improves their function and reduces their pain.
2443 Contrary to what we think as we finger our Med 3 pads, most people with work-related pain do not take time off work but carry on, with reduced efficiency.
2581 The standard measurement in heart failure is the systolic ejection fraction, but this predicts almost nothing (see *Eur Heart J* **24:** 2046), whereas a score based on creatinine, sodium, blood pressure and comorbidity proved highly predictive.
2685 The place of anticoagulation for patients with atrial fibrillation was established with trials that excluded up to 95% of 'real-life' patients: this study looks retrospectively at a patient database and shows that the benefits are definite, and large.

Other Journals:
Arch Intern Med (**163:** 2469) shows that if a patient is over-anticoagulated, oral vitamin K (phytonadione) is at least as good as intravenous. Many women think they are losing their marbles in the menopause, but does hormone replacement help? Not according to a cohort study (2485).
There's been an enormous amount written about insulin resistance, but is there any simple way to detect it? Just measure the triglycerides, according to a study of overweight people in *Ann Intern Med* (**139:** 802).
Hypertension cured by vaccination? Maybe, one day, if they succeed in blocking angiotensin-1 with the aid of limpets — see *Br J Clin Pharm* (**56:** 505).

Plant of the Month: *Galanthus elwesii*
The Plant Finder lists 200 different snowdrops, but I'm grateful for any kind: this one's bigger than most.

Postcard 7 ... Is art the finest teacher? Fine art and medicine

All I want to say is that the only possible teacher, except torture, is fine art.

THUS the late Bryan Robertson, quoting George Bernard Shaw, in an article reprinted in *The Guardian* to celebrate the life of a formidable and crusading art critic.[1] He continues, describing visitors to the National Gallery, that 'hardly anyone exploring this great collection of masterpieces has any idea of what they are looking at. These glowing works of art now have merely an exotic presence of scene or incident, trivialised by ignorance into pleasing. What they're really telling us might just have well have been wrought in impenetrable sign language by aliens.' Shaw believed that looking at great pictures could be supremely educational, and Robertson berates us for not making the effort.

Is this of any relevance to the study and teaching and practising of medicine? And particularly that of general practice?

No modem viewer can be expected to have the range of information relating to classical mythology of a previous age in which exposure to the classics was a foundation of any education. Similarly, any common, uneducated man in 16th century Europe would understand the symbolic significance of certain objects in a painting, information denied to the modem audience. We understand the symbolic significance of a swastika or a mushroom cloud in a painting, but cannot be expected to know that the presence of a lute in a Dutch genre painting signifies erotic lust. We must not confuse information and knowledge: information can be transmitted by, for example, a book or an audio guide to an exhibition, whereas knowledge is retained for possible recall to aid more profound understanding. Notwithstanding all this, to return to Shaw's quote, are there any lessons to be learned from fine art which are specific to the practice of medicine?

Firstly, looking at paintings teaches us to look closely, and to cast off preconceptions. The artist attends to nature by close observation, the doctor attends to patients, and the more keenly the doctor looks and listens, the more likely is the correct conclusion. Claude Monet in his *Rouen Cathedral* series taught us that a grey building is not grey at all, but, depending on the prevailing conditions of light, a grey building contains literally all the colours of the rainbow if we look at it without preconceptions. Similarly the snow in Monet's winter landscapes is not white, but is pink, blue, grey and purple, all in the same landscape.

Looking closely at a Cubist painting is a fascinating experience because, paradoxically, the apparent complexity and fragmentation of the objects reflects, much more realistically than a conventional still life, the experience of seeing. Think, for example, of how we experience a vase sitting on a table in a room. Our experience of that object is not by sitting static gazing at it from one point, but experiencing the object from many different angles as we walk round the room. We have become used to the depiction of objects from a single static view point and therefore find cubism confusing, but by abandoning the tyranny of perspective, Cubisin has destroyed the artificiality of a single viewpoint in both

The Fall of Icarus Pieter Bruegel. Royal Museum of Fine Arts of Belgium, Brussels

References
1.Robertson B. Every picture. *The Guardian* 2002; **23 Nov:** [Reprint].
2. Hockney D. *Secret knowledge.* London: Thames and Hudson, 2001.
3. Auden WH. Musée des Beaux Arts. In: Mendelson E (ed). *Selected Poems.* London: Faber & Faber, 1979

time and space. Unravelling a cubist picture by close observation much more accurately reflects the psychology of visual experience in our everyday lives.

In his magnificent television programme and subsequent book *Secret Knowledge*,[2] David Hockney proves conclusively, in my view, that artists have used optical lenses to achieve accuracy of naturalistic depiction as far back as Jan van Eyck in the early part of the 15th century. Hockney was alerted to this by his close observation of paintings, noticing that folds and patterns in tablecloths moved in and out of focus indicating the movement of a lens or mirror. It is so obvious when it is pointed out, but the reason that we have not noticed this previously is that we simply have not looked at pictures closely enough. Take, for example, one of my favourite paintings in the National Gallery in London, Caravaggio's *Supper at Emmaus*. Hockney discusses various technical aspects of this picture including a discrepancy in the size of the hands which, once again, is obvious when pointed out. But the most striking aspect of this picture, which I completely failed to notice before, is that, of the three persons in the picture, two of them are gazing at Christ's face and the third, Peter, sitting to the left of Christ, is gazing not at Christ's face, but right past him. The explanation is that the actors performing the tableau which was reflected by mirrors on to a canvas which Caravaggio could then trace, had to be allowed to move around from time to time and could not attain the exact position which they had previously taken up, thereby resulting in this anomalous gaze. I have stood in front of this painting on numerous occasions, but totally failed to notice this obvious fact until it was pointed out by Hockney. Looking at paintings, therefore, teaches us to observe our patients closely with all our senses.

Not only does fine art teach us to observe closely, it teaches us to observe without preconceptions. How many doctors bring preconceptions to a consultation? 'Junkies', 'scrounger', 'neurotic, just like her mother', 'probably illiterate and doesn't wash'. If there is one message that life has taught me it is that preconceptions are invariably mistaken and misleading.

Some years ago I was in the Tate Gallery near Picasso's *The Three Dancers*. In this painting the central dancer, a woman, stands erect with her arms outstretched, with two other dancers one on each side of her. At the back of the painting there is the black silhouette of a face outlined against a window. A teacher and a group of children about 8 years old approached the painting and the teacher began to ask them simple questions about the picture. The following answers or observations emerged: 'That lady in the centre looks like Christ on the Cross.' 'Who is that man at the back? He looks very sad.'

By approaching this picture with no preconceptions, these young children had completely understood its meaning and the reason for Picasso painting it. He painted it as a homage to a friend who had committed suicide, and he is 'the sad man' at the back of the picture.

The picture is indeed a religious homage, with a central Christ-like figure and the dancers on either side representing the two thieves crucified on either side of Christ as is usually depicted in the standard crucifixion scene.

We must understand that an artist has an infinite number of choices when painting, in subject matter, in viewpoint, in colours, in structure, and to understand the completed painting it is necessary to ask oneself simple questions without preconceptions. Exactly the same can be said of a consultation in general practice. There are an infinite number of reasons why a patient may present to a doctor. It is by attending closely to the patient both visually and aurally, without preconceptions, that the doctor can discern accurately the root cause of the presentation.

Looking at paintings teaches us to look beneath the surface of the action in the picture to seek another agenda — the real meaning of the picture, as we have sometimes to look beneath the surface of a consultation to seek the real meaning of a clinical presentation.

Take, for example, Bruegel's painting *The Fall of Icarus*. In Greek mythology, Icarus is the boy who is given wax wings by his father, Daedalus, and who, filled with pride, flies to close to the sun and so falls to his death in the sea. In Breugel's representation, the most prominent character in the composition is a ploughman with his horse in the foreground beside whom there is a shepherd with a flock of sheep, and a fisherman. A large and delicately rigged galleon sails majestically by, and, almost invisible, in the right lower part of the picture, are two small legs emerging from the water. The subject of this painting is not the fall of a hapless boy, but Bruegel's realisation that suffering occurs totally ignored by the world and everyone in it. The ploughman, the fisherman, the boy, the ship, all go casually about their business.

WH Auden, looking at Bruegel 500 years later, didn't miss the point:

About suffering they were never wrong,
The Old Masters: how well they understood
Its human position; how it takes place
While someone else is eating or opening
a window or just walking dully along[3]

Experienced general practitioners will be aware of consultations where the presenting complaint conceals the real agenda of the consultation. Where the presenting patient is not the actual patient but the real problem is another family member, or something else, subtly displaced, hidden beneath layers of varnish, or allegory. Reflecting on fine art can sensitise the doctor to these occurrences and prevent a vain search for organic pathology in a patient whose problems lie in a totally different area.

It is essential that doctors are thoroughly trained in diagnostics and therapeutics — patients expect to meet a doctor with these skills, and rightly so. It is my contention that looking at and thinking about paintings can produce a different sort of doctor: one who is richer and deeper as an individual; one who has not only highly tuned clinical skills, but also a more profound understanding of the human condition and of the psychological and moral subtleties that illness so often sets in motion.

In *The Mystery of General Practice* Heath writes: All aspects of human existence are legitimate concerns for the general practitioner provided that they are presented as a problem by the patient.

Fine art promotes reflection on all aspects of the human condition, equipping us for the infinite scope and complexity of presentations in general practice. A good GP is one who listens, understands, and analyses effectively the problems presented, but in our understanding we are inevitably confined by our conceptual framework. It follows that the greater the expansion of our conceptual framework, the deeper our understanding of the problems presented by our patients.

There will always be a need for wisdom and judgement in general practice, and I contend that the attainment of this wisdom can be enhanced by reflecting on fine art. Looking at and reflecting on paintings can teach us to attend closely to our patients without preconceptions, and can sensitise us to the presence of a hidden agenda in a clinical presentation. Assuming a sound knowledge of diagnostics and therapeutics, the study of fine art is infinitely more successful in producing fuller, richer doctors than the torture of further exposure to the biomedical sciences.

Bryan Robertson continued… 'Shaw's observation is profoundly true. If you study art in proper depth, you have to learn about everything; the chronology and history of serfs and princes, religions, agriculture, geography, architecture, clothes and costumes, botany, astrology, astronomy, legend, myth, politics, mathematics…'[2]

If you also plan to study general practice you also have to learn about everything. Fine art is a good start.

Benny Sweeney

The social geography of general practice

THIS essay explores an area of the general practitioner's (GP's) expertise usually taken for granted, which I believe to be of great importance, namely an understanding of the social geography of the practice. I have made use of a concept in common use among social geographers: the 'mental map'. An understanding of this concept could be of value to GPs, and its use could profitably be included in their training.

William Pickles, writing in 1932, started his justly famous book *Epidemiology in a country practice* with an account of the history and geography of the area of Wensleydale that he shared with his patients.[1] His epidemiological findings depended upon his social and geographical knowledge (including the routes taken by the postman) of the whole area, and were based on his intimate understanding of the social structure of his community. Although the scope of general practice has changed in recent years, I believe that such knowledge remains relevant: the re-publication by the RCGP of John Berger's *A fortunate man* supports this view.[2]

All GPs absorb, largely unconsciously, a vast store of essential information about the area in which they practice. I seek to interpret, with two examples, some of this knowledge base. This interpretation is based on both my own experiences as a GP, and on interviews with 30 GPs.[3,4]

The Author's provenance
I came into general practice from a background of family psychiatry. My recollection of general medicine was rusty, so I was grateful for a trainee year, during which I realized how little I knew. I frequently consulted my trainer whenever I was uncertain, and valued his experience and knowledge of medicine, but I found increasingly that his advice was based, not on his knowledge of technological medicine, but on his personal understanding of the patients, the significance of their addresses, their problems, their families, their employment history, and their housing problems.

In due course I became a GP trainer; the trainees who joined my group practice came straight from hospital, where they had been employed as junior doctors.

Without exception their knowledge of scientific medicine was far superior to my own; the only advantage that I had over them was in my personal knowledge of the patients and of the social geography of the practice.

The scope and knowledge base of general practice

Until recently all GPs contracted to provide 24-hour medical care for every patient on their list and a key element was that the GP was expected, in any case of serious illness, to visit the patient in his or her own home. This privileged, confidential access is the foundation on which all doctor–patient relationships are based. For GPs, such access is geographical, as well as medical and psychological. I refer to their privileged familiarity with patients in their homes, gained over many years, and suggest that information gained by such confidential access, often taken for granted, is a major component of the GP's knowledge base.

In addition to medical information that can be recorded on patients' notes, GPs gradually absorb a range of kin-related, social and geographical, historical and ethnographic data which is carried in their heads. The possession of this privileged information is a major advantage that GPs have over all other doctors.

GPs' 'mental maps'

I borrow a concept from human geography, namely the 'mental map'.[5-7] In order to negotiate the world around him every individual constructs an internal image, a mental map of the personal world that he inhabits. Every mental map is unique to the 'cartographer' who constructs it; it is fashioned from his personal experiences, and is a reflection of his particular style and perspective, his business concerns, interests, prejudices, likes and dislikes. Thus, the mental map of a policeman will be very different from that of a farmer, and different again from that of a child.

The map is always patchy and incomplete, some areas are full of detail, others relatively bare. The map is plastic, it changes continuously as old information becomes redundant and new information is added, it becomes modified also as the map-maker himself expands his horizons and learns to view the world differently.

All mental maps are distorted by the personality of the map maker, yet the information, once stored, may be manipulated and is essential for all planning. Although the importance of medical geography is well recognised,[8-11] references in the medical literature are limited.

GP trainees commonly join a practice for two discrete periods of 6 months. Although their knowledge of scientific medicine often outstrips that of their trainers, it is generally acknowledged that it can take years before a trainee can make a useful contribution to the work of the practice. There is much to learn: having familiarised himself with the premises, social structure, and foibles of his colleagues, he must find out about the available medical services in clinics, consultants, services, who is or is not efficient and reliable, the area, the hospitals, and how best to obtain their services.

The new partner or trainee will usually be presented with a map of the practice area. It is important that he becomes familiar with this quickly, since in an emergency lives may depend on his ability to reach the right house with all speed; this entails familiarity with the vagaries of British street numbering, and some streets are very vague indeed.

During the ensuing months and years the new GP constructs an internalised map on the foundation of the real one. He very soon discovers the physical geography and the climatic variation of the landscape, perhaps also the geology.[1] He learns the town and village plans, their development and their relationship with each other, he finds out about communication systems, public transport, roads and how these may be affected by weather conditions (country roads may be blocked by snow, and whole villages may be cut off). He soon discovers the social and ethnic as well as the geographical significance of an address. In

large cities he will need also to become aware of the problems of homelessness.

The GP will discover the economic infrastructure of the community, the shops, markets and supermarkets; he will be brought into contact with local industries, he will encounter local politics and politicians, he will read the local newspaper. He will learn about patterns of local employment and unemployment.

The GP's mental map will quickly become populated by patients and their families; houses and flats with elderly grandparents, busy parents, single harassed mothers (and fathers), surly teenagers, unruly children, and unwashed snuffling babies. And pets. Increasingly also there are care homes, for the infirm elderly, chronic psychiatric patients, and long-term physically or mentally disabled, each with its characteristic decor.

The map will contain information derived from other senses besides sight. The GP will record, largely unconsciously, not only the external appearance, but also the interior of the homes that he visits, their decor and furnishings, the pictures, the carpets, the wallpaper, the state of cleanliness. He will be able to use the map in order to recall, not only how the houses look, but also how they sound and smell; the general living conditions and lifestyles of the residents, the TV programmes that the children were watching, that he had to interrupt. (A GP of my acquaintance believed that if he were blindfolded he would be able to identify most of the houses that he visited by smell alone. Every house has its own unique aroma compounded of cooking, body odours, perfumes, cleaning materials, washed or unwashed children and pet food.)

The map never remains constant; old houses are pulled down, new ones are built, dwellings become empty and are re-inhabited, new relationships are formed, babies are born, people die, families move in or leave the area. All these changes become incorporated into the GP's mental map.

But the map also has a historical dimension: the old torn-down streets, past patients, major past events, all remain recorded upon it. Over years the GP has an opportunity to understand the kinship and affinal relationships within his practice, going back over many generations. None of this information is codified but will be available when required.

In country districts it was (and may still be) customary for the doctor, once his services had been requested, to walk straight into the patient's house without waiting to be let in. He expected to find the door unlocked, and usually announced his presence by calling 'Hello! Doctor!' as he walked in. He would continue this practice for repeat visits. I know of no other profession that has this unrestricted informal right of access to people's homes.

This privileged right of confidential access into patients' homes was taken for granted by most doctors and accepted by most patients. The GP's mental map of the patient's external environment is mirrored by his mental map of his patients' body, and often of his mind also. I argue that this right of access to both patients' homes, and patient's bodies is the GP's greatest advantage as a healer.

The GP will soon learn about the major sources of employment in the area, their reputations, who owns and manages them, who is employed where. He will get to know the shops, the pubs, the publicans and who visits them; the churches and the clergy; the police station and the policemen; the social services; the old people's homes and the undertakers; the caretakers, formal and informal; the schools and the teachers, and the children who go to them. He will soon find out about the patterns of land and housing tenure, both private and public. He will inevitably get involved with the housing problems of the area, with sheltered housing and homelessness, and this is likely to bring him into contact with his local authority officials and councillors. Through his working relationships the GP will learn about the social hierarchy operating within the district, and the structure within which it functions. He will also discover the informal care networks, the key figures in the community who can be relied on to give neighbourly support at any time.

The GP's map soon begins to contain historical information about the local neighbourhood. The area in which I practised was dominated by two major features; firstly, a large manor house which had been inhabited by the same family for 700 years. This family owned most of the agricultural land and much of the older housing in the practice. Although their influence had diminished, the hold that they had over their tenants was in many ways feudal. The other geographical and historical feature, of great social and medical significance, was the presence in most villages of abandoned derelict mines. Many of these villages had been built to serve these mines; their closure over a period of 30 years, after the Second World War, brought economic disaster to the area, and the stark ruins of the pithead buildings were a reminder of that bitter period of local history. Many of the older men in the villages had been employed in the mines, and were permanently scarred by the experience.

The construction and use of the map

GPs are not trained in cartography or ethnography; the map-making process is largely unconscious and is therefore private and non-replicable. It cannot be displayed; it is a working tool, constructed through experience and use; it is continually being added to and reconstructed. Although individual pieces of information may be passed on to others, it cannot be copied, and much of the information it contains is sensitive and privileged. The map will always have blank areas; some families never consult doctors, or they attend the adjoining practice; nevertheless, this ethnographic and geographical knowledge forms an indispensable part of the GP's equipment.

The following two clinical examples illustrate some of these points.

Example 1 — a case of fatal dis-location: Mr West's 'farmhouse'

First, a formal medical case history:

Mr West, an 84-year-old widower and retired farmer, was admitted to a geriatric ward with increasing breathlessness and decreasing mobility. He had a history of ischaemic heart disease and osteoarthritis. It was established that he had lived by himself in his farmhouse since the death of his wife 6 years previously, and that he was a pipe smoker. The junior hospital doctor learned that Mr West's mobility had gradually decreased, and that he had not left his house for the past 2 years. For some weeks he had eaten little and had been confined to his bed; of late he had seemed to be confused and depressed. The junior doctor heard from Mr West's son, George, who now ran the farm, that his father's condition had deteriorated rapidly during the previous few days. Mr West himself seemed confused and was unable to give any history. The doctor who examined Mr West found him to be emaciated and rather dirty. There were signs of bronchopneumonia and congestive heart failure, which were confirmed by X-ray. Mr West refused all further investigations. Unfortunately he failed to respond to treatment and he died a few days later. The cause of death, according to the death certificate, was bronchopneumonia secondary to ischaemic heart disease.

Now, with the aid of the GP's mental map, a 'thicker'[12] description:

Seven years previously Mr West had been active for his age, despite a long-standing, well compensated, heart complaint. His 50-acre family farm was on marginal land on the edge of a former mining village, and had for many generations of Wests been rented from the local landowner, Lady North, who inhabited the manor house nearby. The

estate was run by her agent. Small tenant farmers had been evicted and the land incorporated into the large estate farm farmed by a manager. Mr West's farm was nominally devoted to the raising of cattle, but Mr West's family had for years run a profitable side-line through the rearing and breaking of hunters (horses), for which the family was renowned. Mr West thus had made himself and his farm indispensable to the local gentry.

Mr West was a 'character', with sharp features and a lean stringy physique. According to his son, George, he had 'always been a cantankerous old sod'. Mr West possessed strong views about everything, which he expressed in colourful language — 'bugger' figured prominently in his vocabulary. On horses, 'You've got to show t'buggers who's boss'. He used similar phraseology about women, children, cows, newspaper reporters and all local authority officials. On George, who became dispirited by his father's battles with authority, he said to the doctor, 'Can't you give'n some'at to make t'bugger bounce?' But he was a good farmer, deeply attached to his soil, about which he spoke with feeling — 'Hunger t'land and it will hunger thee.'

Mr West, a widower, lived in a semi-detached house a short distance from the farm. George, who lived nearby, did most of the work on the farm, but left all major decisions to his father.

The original farmhouse had long fallen down, but the farm adjoined a village erected 100 years previously to house miners; typical, terraced, red brick, miners' cottages, each with a yard, external toilet and wash-house. They stood on a ridge commanding a fine view of open countryside and were inhabited by a close and lively community of ex-miners and their families. After the closure of the local mine the houses were taken over by the local authority, who deliberately spent no money on them; as a result they were in a very poor state of repair.

Mr West held the tenancy of a house at the end of the village, formerly a pub, which happened to be close to the gates of his farm, but he did not at first live in it. The house had stood empty for some years, and was used only for storing farm equipment and cattle feed.

The undeclared policy of the local authority was to get rid of smaller pit villages, since they were unsightly and expensive to maintain. Eventually, the council announced its intention to demolish the two streets on the grounds that they were 'unsafe', and re-house the residents in 'suitable accommodation' wherever and whenever it became available. It was rumoured that the council intended to sell the site, on prime building land, to private developers, though this was denied.

The council maintained that the houses were unfit for habitation. The residents, ex-miners' families who formed a close and living community, organized a series of protest meetings at which they were supported by all their GPs, but the council were adamant. Vague promises were made (and not kept) about the possibility that the community might be re-established in new houses near the old site. But despite protests, eviction notices were served to every householder.

Mr West attended none of these meetings, but when he realized that the council were determined to clear the site, he moved into the empty pub. Over the next 2 years the residents were evicted, and scattered. The community disintegrated and the old houses were boarded up prior to their destruction. Finally, all were emptied, except for the semi-derelict old pub that Mr West now occupied, and designated as his 'farmhouse'. He maintained that it was essential that he remained in the farmhouse so that he could keep watch over the farm and the stock. He engaged in a long legal battle with the council; he persuaded a reporter from the local paper, 'one of them buggers from the *Gazette*' to interview him and write a sympathetic report; he wrote angry letters to his MP; he enlisted the support of Lady North.

Now in his eighties, Mr West's health began to deteriorate, he gave up breaking horses and his visits to the farm became infrequent. But he would not leave the 'farmhouse' insisting that it was essential that he should 'keep an eye on the buggers'. Eventually he became housebound and his GP used to visit him at home regularly. He received 'meals on wheels' and he was visited by a social worker from the council who made him tempting offers of sheltered accommodation.

He refused; 'I know what the buggers are after', and he tried to persuade his doctor to write a letter stating that he was not fit to be moved. The council pulled down all the other houses. Until only Mr West's 'farmhouse' remained.

Thus it stayed for another 2 years, since the private builder who had been offered the plots refused to complete the transaction until the whole site had been cleared. At the time Mr West moved in the house was already semi-derelict, its condition began rapidly to worsen. The council refused to spend money on a condemned building, so Mr West withheld the rent and started litigation against them for their refusal to repair the property. He would not move despite repeated eviction notices. On the date that the last eviction order ran out, Mr West made sure that journalists from local and national newspapers would be present to record events. Nothing happened. No formal stay of execution was granted, but it was recognised that Mr West had won.

References
1. Pickles W. *Epidemiology in a country practice.* London: RCGP, 1984 [reprint].
2. Berger J. *A fortunate man.* London: RCGP, 2003 [reprint].
3. Holden HM. An enquiry into the status and authority of healers, with reference to general practitioners. Dissertation. Durham: Durham University, 1989.
4. Holden HM. The mask of the healer. PhD thesis. Durham: Durham University, 1997.
5. Gould P, White R. *Mental maps*. New York: Penguin, 1974.
6. Seamon D. *A geography of the life world.* New York: St Martin's Press, 1979.
7. Lowenthal D. *The past is a foreign country.* Cambridge: Cambridge University Press, 1985.
8. Knox P. *Urban social geography.* New York: Longman, 1982.
9. Black D, Morris JN, Smith C, Townsend P. *Inequalities in health care.* Report of a research working group. London: DHSS, 1980.
10. Philimore P, Beattie A, Townsend P. Widening inequalities in health in Northern England. *BMJ* 1994; **308:** 1125.
11. Hart JT. The inverse care law *Lancet* 1971; **i(7696):** 105.
12. Gertz C. *The interpretation of cultures.* New York: Fontana, 1973.
13. Cartwright A. *Patients and their doctors.* London: Routledge & Kegan Paul, 1967.
14. Engels F. *The condition of the working class in England.* London: Panther, 1969 [reprint].
15. Snow J. *On the mode of communication of cholera.* London: Churchill, 1855.
16. Kleinman A. *The illness narrative.* New York: Basic Books, 1988.
17. Good BJ. *Medicine rationality and experience.* Cambridge: Cambridge University Press, 1994.
18. Bursztajhn HJ, Feinbloon RI, Hamm RM, Brodsky A. *Medical chances, medical choices. (How patients, families and physicians can cope with uncertainty).* London: Routledge, 1990.

Gradually, over the ensuing years the fabric of the house deteriorated. No further eviction notices were issued but the council would not repair the property. All they had to do, was wait.

Meanwhile, the roof leaked, the upstairs ceilings fell in, and the stairs became rotten and unsafe. Mr West did not mind as he never went upstairs. The two downstairs rooms in which he lived were dark, dreary, damp, and very dirty. The only heating was a Victorian kitchen range, which smoked.

Food was provided by 'meals on wheels' but no cleaning was carried out since Mr West did not consider it necessary. The condition of the two rooms which he occupied became increasingly insanitary due to damp and decay. Finally, the flooring in his bedroom started to collapse into what used to be the beer cellar.

During this period the GP used to visit Mr West, but a point was reached at which he felt bound to intervene. Mr West's mobility had deteriorated greatly over the months. Now he was immobilised by osteoarthritis, and the damp conditions in the house were affecting his chest. Finally, the 'meals on wheels' lady and the district nurse refused to enter the house because it was unsafe. The GP then put pressure on Mr West to accept admission to hospital. Mr West at last gave way, and in fact gave up. Without his farm he had no reason to live.

Within weeks of his death the council started to demolish the 'farmhouse'. The whole site is now occupied by desirable executive residences.

Example 2 — map failure

Occasionally, the GP's mental map fails him, as though his inner global positioning system has been switched off. An old patient comes into the consulting room out of his proper turn; I am aware that I should know him, but for the moment his identity escapes me. It is clear from his manner that he expects me, his doctor, to know not only who he is, but everything about his case, his history, and his social and family background. Although his notes are somewhere on the pile on my desk I cannot immediately locate them because I do not know his name. I feel de-skilled. The one thing that I do not feel able to say is, 'I'm very sorry, I have no idea who you are; please tell me your name.'

Forgetting a patient's identity is, for a GP, more serious than ignorance about technological medicine. The latter can be looked up, but the understanding of the dynamics of the families and communities that make up his practice can only be built up through experience. Patients expect that this understanding, once gained, should be retained. Cartwright makes the same point in her study;[13] GPs are valued, not so much for their technical knowledge, as for their humanity and the interest which they take in their patients as people. Most GPs are familiar with this emergency and develop their own methods (trade secrets) for dealing with it.

Discussion and conclusions

I have chosen to focus on only one of those patients who were affected by the local authority's decision to clear the houses. The final closure of the mine was the end of a way of life, which had had a profound effect on all the residents of the village; the clearance of the village was the last devastating blow, which had an effect on the health of many others besides Mr West.

Only Mr West, 'a cantankerous old sod' deeply rooted in the land which he farmed, was prepared to take on the bureaucratic system and was determined not to be dislodged! It may be doubted whether the GP's final intervention did anything to prolong Mr West's life or relieve his suffering. The GP was frequently asked, as an expert, what would be in Mr West's best interests? It was suggested that it might be kinder, in view of the appalling condition of the farmhouse and his poor health, to re-house him in comfortable, sheltered accommodation against his will. Was he really well enough to know his own mind?

To none of these questions could the doctor give a certain answer, perhaps no one could; but the underlying social, historical and geographical issues were relevant and unavoidable. Such situations are relatively common and most GPs are familiar with them.

If the GP is truly an expert, what is the nature of his expertise? I believe that a large measure of the GP's skill rests on his geographical, historical and ethnographic knowledge of his practice, acquired through his privileged access, not only to the bodies and minds of his patients, but also to their neighbourhoods, their kinship networks, their homes and their communication systems. Armed with this information, most family doctors could give 'thick descriptions' similar to the one undertaken here. The social, geographical and historical issues raised by this example are extremely complex, but all are relevant to his everyday work. In all such cases his mental map is available and is used, often unconsciously, in decision making.

The importance of geographical factors on health has been well recognised since Engels' observations on the conditions of the working class in Manchester.[14] John Snow's conclusions about the spread of cholera in London were the direct result of a geographical survey, linking cholera houses with their supply of water from the Broad Street pump.[15] More recently, Knox has drawn attention to the uneven distribution of medical care in urban areas;[8] medical facilities tend to be concentrated in the more desirable areas, and this conclusion is reinforced by Tudor Hart's findings.[11] The Black Report provided conclusive evidence of the association between poor health and bad housing conditions,[9] and the social anthropologist Philimore provided further evidence linking lifestyle with health,[10] but these important studies are on a scale remote from the everyday working life of a GP.

As I accompanied the GPs in my interview series on their morning calls they told me about the countryside and its history, the abandoned mines and their 'Category D' villages, of which little sign remained, and of the devastating effect that this loss had on the local economy, and on those who remained who were now their patients. They knew their patients personally, and as we drove through the countryside they would outline their medical, social and psychological histories in the context of that countryside.[3]

The trend in academic medicine is towards increasing fragmentation into specialities and sub-specialities. The RCGP has made a laudable attempt to counter this trend, and to consider the health of the whole person. Kleinman made a plea that illness should be interpreted and treated in the context of the patient's everyday life, rather than the 'scientific' atmosphere of an American hi-tech hospital.[16] Good[17] and Bursztajhn *et al*,[18] have argued similarly. I had hoped that such pleas were unnecessary among GPs in this country, although the new GP contract makes me now question this. But I believe that the GP's task would be made easier if it were officially recognised that their work depends quite as much on their understanding of the complex family and social dynamics of the community, based on privileged access, as upon scientific medicine.

I believe that this understanding, for which GPs have little formal training, is closely linked with the willingness of patients to disclose the inner secrets of their homes, their minds, and their bodies. Thus, GPs inevitably become geographers and ethnographers.

If this view is correct, perhaps it would be helpful to include elements from these other disciplines in their training?

Hyla Holden

Master and Commander: The Far Side of the World
Peter Weir, 2003

WHEN I was a medical student I decided that my violin playing needed improving, so I sought out a teacher. Probably I should have concentrated on anatomy rather than music, then I wouldn't have failed my exams. On the other hand, I still play the violin and have forgotten most of my anatomy. Not that the violin lessons lasted all that long. My teacher shared with me an enthusiasm for the navy of Nelson's time, malt whisky, and plank-on-frame ship models (he never finished the USS Constitution and I never finished the Cutty Sark).

It was he who introduced me to the novels of Patrick O'Brian. These exquisitely written sea stories chronicle the adventures of a Royal Navy captain, the superficially bluff 'Lucky Jack' Aubrey, and his friend and ship's surgeon, the Irish-Catalan physician, naturalist and spy, Stephen Maturin. Over the next three decades we eagerly awaited each new volume. On one thing we were agreed: any film of these books, with their painstaking historical accuracy and elegant style, would be a travesty. Sadly, my friend died three years ago, so when the film came out only one grumpy old man was left to sit among the popcorn-crunching hordes, ready to sneer at Hollywood's take on our sacred texts.

My sneering never got started. Peter Weir, the director, has created the illusion that the film was shot in 1805. Every nautical and social detail rings true. We are made to believe that this is exactly what it was like to serve in a Royal Navy ship of the period. In the opening scene the 28-gun Royal Navy frigate HMS Surprise, under Aubrey's command, is ambushed off the coast of Brazil by the much larger and more powerful Acheron, a French privateer that Aubrey has been ordered to intercept. After repairs, Aubrey pursues the Acheron all the way down the east coast of South America, around Cape Horn, and up the west coast as far as the Galapagos Islands before attempting to take her.

Russell Crowe as Captain Jack Aubrey in 20th Century Fox's *Master and Commander: The Far Side of The World*.
© Copyright 20th Century Fox

Russell Crowe as Jack Aubrey and Paul Bettany as Maturin are utterly convincing. As in the books, moral, philosophical and practical dilemmas are explored through their relationship. As his friend, Maturin challenges Aubrey's determination to pursue the Acheron — is it pride or duty? But as a subordinate over whom Aubrey has literally the power of life and death, he must obey him. Crowe shows Aubrey's exemplary qualities of leadership, professionalism, courage and humanity. He is fearless and calculating in battle, can inspire his men with rousing rhetoric, but in the evenings he and Maturin play violin and 'cello duets.

Bettany reveals Maturin, the skilled surgeon and physician — he amputates an arm in an instant, and performs a repair of a depressed fracture of the skull with a silver coin (both patients survive). When he is wounded by accident, his assistant cannot be trusted to remove the bullet from his chest, so Maturin shows his own courage by performing the operation on himself with the aid of a mirror (Aubrey watches aghast). We see him also as a naturalist on the Galapagos Islands, fumbling towards the theories of Darwin.

There are countless superb vignettes of the other officers and crew all faithful to O'Brian's descriptions (and often his dialogue). This is a film about leadership, comradeship and patriotism. The special effects are excellent (the battles and storms are horribly realistic), but it is the gradual revelation of the relationships between all the characters that turns this from a good film into a great one. At the end, when the dead from the final battle are buried at sea, we share their comrades' stoical grief and their conviction that they died in a just cause. Don't miss it.

Toby Lipman

Perceptions of pain
Deborah Padfield
Dewi Lewis Publishing, 2003
HB, 128 pp, £14.99, 1 904587 02 X

Pain is a gift nobody wants

PAIN is a wholly subjective experience, often difficult to describe in words. It cannot be seen, heard, smelt, tasted, or felt by anyone other than the sufferer. Pictures can offer a clear route to depicting pain. Metaphor is almost always used to describe pain in words. Metaphor is a sensual way of using language; the visual being, perhaps, the most impactful sense used.

Chronic pain can affect the whole life experience of the sufferer. Pain can be both diagnostically useful, and invaluable for injury avoidance — under normal circumstances. But chronic pain can go far beyond this human usefulness. In order to treat or diagnose from pain, a clinician needs to understand it as fully as possible. In order to live with the pain, the sufferer needs to perceive it equally clearly. Making pictures, using visual metaphors, can serve both these ends, as well as creating works of art.

This is a deeply moving and useful collection of photographs and accompanying notes. Deborah Padfield, a chronic pain sufferer and photographer, worked closely with pain sufferers at St Thomas' pain clinic (using a SciArt grant). These pictures were created through intense discussion and manipulation of metaphoric images vital to each sufferer. They also made notes: 'At its worst it feels like rusty, hot barbed wire. There is almost a taste of iron. It is wound round itself, twisted up with hot sharp points …' (Linda Sinfield.) The accompanying photo is of glowing barbed wire on a black background — imagine that in your spine.

Brian Hurwitz's preface is an excellent discourse on pain in medicine, and art: 'pain is a gift nobody wants.' Charles Pither gives a pain specialist's invaluable view. Deborah's introduction tells her journey through pain and its photographic depiction. '[Pain] requires a language which works on a more instinctual and primal level than words. One such language is visual language — with its ability to contact the unconscious in maker and viewer. This is where I feel we should be looking when we search for a bridge between the private suffering of an individual and a medical and collective understanding.'

This book should be on the desk of every GP. It is an education in what such people experience. It is also a model — ask your patient to draw their pain, to write about it in metaphors. You might both be helped to understand it.

Gillie Bolton

diary

26 January
MRCGP Examination Preparation Course
University of Portsmouth, Portsmouth
Contact: Carol White
E-mail: cwhite@rcgp.org.uk
Tel: 01264 355005

28 January
Retired Members' Lunch
University of Birmingham, Edgbaston
Contact: Barbara Ingram
E-mail: JL92@dial.pipex.com
Tel: 0121 414 8270

28 January
Transcultural Medicine: Race, Ethnicity and Health
Royal College of Physicians, London
Contact: Conference Office
E-mail: conferences@rcplondon.ac.uk
Tel: 020 7935 1174 ext 436/300/252

28 January
Mental Health (Module 2)
Woodlands Centre, Chorley North
Contact: Jackie Dartnell
E-mail: nwengland@rcgp.org.uk
Tel: 01925 662351

29 January
RCGP New Contract Study Day
Windermere Hydro Hotel, Windermere
Contact: Linda Thorogood
E-mail: lthorogood@rcgp.org.uk
Tel: 01946 590169

31 January
Fellows Meeting
Angel Hotel, Bury St Edmunds
Contact: Annemarie McCarty
E-mail: jc03@dial.pipex.com
Tel: 01223 884324

10 February
MRCGP Preparation Course Module Two 'Written and Oral Papers'
The Four Pillars Hotel, Abingdon
Contact: Sue Daniel
E-mail: tvalley@rcgp.org.uk
Tel: 01628 674014

11 February
Ophthalmology (Module 2)
Manchester Eye Hospital, Manchester
Contact: Jackie Dartnell
E-mail: nwengland@rcgp.org.uk
Tel: 01925 662351

12 February
Health Information Workshop
Civic Centre, Aylesbury
Contact: Linsey Hovard
E-mail: linda.bonney@phru.nhs.uk
Tel: 01865 226707

18 February
Delivering Solutions, Improving Performance — the 3rd clinical information conference
Novotel, Hammersmith, London
Contact: Charlotte Hall
E-mail: charlotte.hall@nhsia.nhs.uk
Tel: 01962 814415

neville goodman

Mad as a respiratory physiologist

THE mercury sphygmomanometer is to be banned: there is a European directive. Mercury is just too nasty to let loose in hospitals. It's a shame, though.

That first time you wrapped the blue-grey cloth around the patient's arm, pumped hard on the bulb and then gazed intently at the falling column of mercury: that was when you first felt like a doctor. Never mind the clerking. Can you describe the pain? Do your ankles swell? Did anyone else in the family gargle with aniline dyes? And all that pretending to feel for the edge of the liver. It was all play-acting. The real business of being a doctor was taking the blood pressure. You knew it; patients knew it.

Hands up all those who clamped the closed end of the stethoscope to the antecubital fossa, heard nothing, and then copied down the blood pressure from the nursing Kardex. 'Is my blood pressure OK, doc?', came the anxious voice. Well, it will all be done by machines soon, and measured in kilopascals, though it'll be some time before a blood pressure of 16/10.7 sounds normal, and 26.7/17.3 triggers a shot of hydralazine.

The last time I needed a mercury sphyg it took 10 minutes to unearth one. The bulb's valve was stuck and refused to refill after the first squeeze. The mercury wobbled but failed to rise. Not that it mattered: the tubing was completely perished and snapped as I wrestled to fill the bulb again.

In Oxford in the 1960s, we used the Lloyd-Haldane apparatus in respiratory practicals. Shooting the gas sample around by raising and lowering the mercury reservoir was great fun. If you tried really hard, you could get the sodium hydroxide into the alkaline pyrogallol, shoot mercury all over the bench, and jam the five-way glass tap solid. Some years later, we substituted polythene replacements for the rubberised canvas Douglas bags that generations of students had breathed into and out of in those practicals. For reasons I'd better not reveal, some of us cut open the canvas bags. There was mercury in all of them, running along the seams. As well as oxygen, nitrogen and carbon dioxide, we'd been breathing saturated mercury vapour. It could explain a lot.

The real shame of abandoning the sphyg, though, is that it is yet another 'advance' that means we touch our patients less — awake or asleep. I see anaesthetists now who, once the monitoring is attached, don't touch their patient again until the operation is over. The occasional whiff of mercury must matter less than that.

our contributors

Neville Goodman has written for the *BJGP* for 5 years or so. For which many thanks, Nev. His occasional grumpiness is this month explained by habitual and excessive exposure to inhaled mercury. And working in secondary care. So more to come.
Nev.W.Goodman@bris.ac.uk

Gillie Bolton luxuriates at King's.
gillie.bolton@kcl.ac.uk

Iona Heath married a distinguished architect. She runs an efficient kitchen.
pe31@dial.pipex.com

Hyla Holden was a psychiatrist, then a GP, in northern England. He has retired to the warmer climes of Bath.

Toby Lipman is a jet-set GP academic from Newcastle, featuring regularly in *Hello!* and the *Journal of the Berlioz Society*. (Students of oxymoron may wish to comment upon that last sentence in a constructive and non-hurtful way — usual prizes available.) In his spare time he fails to complete model ships.
toby@tobylipm.demon.co.uk

Benny Sweeney is a GP in Govan, Glasgow. He has chaired Scottish Council of the RCGP and the RCGP's Ethics Committee. Any typos in his article for us this month are the result of excessive time in Australia this autumn, watching rugby, tasting wine and attempting to scuba dive on the Great Barrier Reef.
brendan.sweeney@gp52058.glasgow-hb.scot.nhs.uk

James Willis would rather readers ignore his elegance of prose and come instead to the 2004 RCGP Spring Meeting, in Bournemouth. Fabulous cast, stimulating programme, and budget flights from Scotland and elsewhere. More detail at:
www.seachange04.com

james willis

The inverse scare law

THE inverse scare law is a name I once suggested for a natural phenomenon.[1] It is different from the inverse square law of physics which states that the gravitational attraction exerted by the sun on the planets or the attraction or repulsion exhibited between two magnets varies inversely with the square of the intervening distance. And it is different from Julian Tudor Hart's inverse care law which states that the availability of good medical care tends to vary inversely with the need for it in the population served.[2] My inverse scare law states that in the modern, media-dominated world the amount we worry about a problem varies inversely with the likelihood of it happening.

In other words, the more we sort out the world's problems so that people lead comfortable and safe lives, the more the remaining problems show and the more people worry about them. It takes a spotless car to show a spot.

In the days when life was a thoroughly risky business, when industrial and domestic accidents were common, when medical treatments were usually ineffective and frequently lethal, and when it was expected that several of the children in every family would die in infancy, people got on with their lives and accepted that everything contained a degree of risk. Since then the enormous strides that have been made in every aspect of safety have had the opposite effect to the one expected. Instead of people feeling more secure they are gripped by something akin to a mass obsessional neurosis with regard to the remaining problems.

To take one example: of all the terrible things that can happen to a child in Britain today (and GPs have as good a grasp of the reality of this as anyone) abduction and murder is one of the least likely. And like other risks it is less than it used to be: W T Stead, editor of the *Pall Mall Gazette*, wrote a series in 1885 about how easy it was to buy children in London for sex. Yet today the salacious attention of the nation is seized for weeks when a case does occur and as a result childhood has been distorted by precautions which intrude into every corner of life: Teachers are forbidden from touching or comforting pupils. Local newspapers are prevented from identifying children in photographs. Parents are made to feel irresponsible if they allow their children out to play, let alone to wander in the fields as my old patients love to remember doing. Who can guess the consequences of such an uncontrolled experiment in changing the upbringing of a whole generation?

Doctors are in the risk business. In this they are unusual today. Even insurers do their best to exclude the people who need them most. But doctors have to take risks all the time, and however perfect they make their practice there will always be residual problems. After all, measured on the parameter of saving lives, general practice has an ultimate success rate of zero. Nor is it enough to aim to practise safely and conscientiously for your whole career. Or for every doctor you know to do the same. If a single doctor does something grossly aberrant, and therefore headline-worthy, your entire profession will come under finger-wagging suspicion, and ludicrously complex, expensive, disruptive and even self-evidently futile precautions will be imposed upon you all.

Now, let's have nobody pretending I'm saying that we should not go on trying to take sensible precautions to increase the safety of our lives! The point is that in many areas we have now passed a balance point and some of the precautions we have imposed in the name of progress are doing a lot more harm than good.

We have taken on the task of legislating to abolish the endless store of rare events which the media selects to feed the public's appetite for sensation. And we are bringing daily life to a halt. We are swamping it with protocols and paperwork which seem, on the ground, to be utterly insane.

We have to tackle this problem at root, by confronting it, talking about it and educating ourselves about it, otherwise there will be no end to it. But in order to do that we have to give 'it' a name.

References

1. Willis J. *Listen to the juggler. The 2001 George Swift Lecture*. www.friendsinlowplaces.co.uk/GSLecture.htm.
2. Hart JT. The inverse care law. *Lancet* 1971; **i(7696):** 405-412.