The Back Pages

viewpoint

Sanctuary in Glasgow

DISPERSING asylum seekers around the UK has been a controversial, although arguably a necessary policy. An increase in people seeking asylum had overstretched the infrastructure of London and the south east of England. In 1999 Glasgow City Council agreed to take many thousands of distressed and destitute individuals. The decision was made with little discussion and was viewed with some misplaced cynicism by Glasgow citizens. Our inner city had many empty council-owned properties with a declining population and half empty schools. Taking in asylum seekers and changing them into 'New Glaswegians' would bring in much needed money from central government, in addition to doing basic humanitarian good.

Our local media was hostile in its indifference, initially ignoring then over-reacting when prodded. This trait continues with the controversies of Dungavel and threatened child removal for failed asylum seekers. The media portrayed buses full of families on the road to Glasgow, before any meaningful discussion had taken place with social work and medical services. Television cameras and spotlights greeted these frightened families, who sometimes refused to get off the bus. With the lack of planning there was an excess of apprehension. Practices would be 'swamped'. Workload would be intense with tropical diseases, TB and worse. Very real fears arose that inner city practices might have to take on hundreds of new patients, taking them either with good grace, or closing their patient lists to all.

The reality has been very different. Yes, initial planning was pretty awful. But the lack of foresight and logistics have been countered by the hard work and resourcefulness of front line staff, often agreeing to take on extra responsibilities before resources had been put in place. In my own practice we took on the care of almost 200 asylum seekers, all living in grim multi-storeys, within 1 mile of the practice.

There have been far more benefits than drawbacks. We have been given a full-time practice nurse and receptionist, and we were fortunate that they were in place before most of our new patients arrived. Our new staff are both efficient and cheerful, and move mountains.

We have also been given a new take on how we work, and see our country and the rest of the world. It may be wet and dark here much of the year, yet it must be attractive enough for people to travel half way around the world to get here. The 'New Glaswegians' are disparate, from Iran, Iraq, Afghanistan, Congo, Somalia, Zambia and Eastern Europe with greatly differing religions and customs. They are, however, mainly in their 20s and 30s, middle class, often professional, and invariably more deferential, more reliable and more considerate than our usual clientele. The bulk are desperate to work, and to create a better life and future for their families. We have been fortunate in seeing few who have been tortured or brutalised, although many have sad stories of oppression or of missing family members. The illnesses we have seen have, by and large, been similar to those we regularly see, with no evidence of 'health tourism'. Psychological problems are prevalent, often only unearthed on probing. My most common medical problem has been explaining the waiting list system, with patients not used to having to wait 6 months for a routine Out Patient appointment — why is the organisation of a health service in such a wealthy country so inept?

Scotland, and more so Glasgow, has an ageing and declining population. Our cities and central belt have many who are benefit-dependent, lacking initiative and enterprise. We need an injection of young educated adults who will teach our young, nurse our elderly, create businesses and pay taxes. My 'New Glaswegians' frequently complain that they are not allowed to work, although many are being absorbed into the black economy, doing menial jobs. Most have a trade or profession and are desperate to earn money.

Our situation in Scotland is quite different from that in the overheated South. We need people who are going to take an active role in our development and who will help reverse our decline. This has been recognised by the Scottish First Minister who wishes to grant more work permits in Scotland, as part of a plan to attract more skilled workers, the 'fresh talent initiative'. The truth is that we need them more than they need us, and that we should welcome them with open arms.

Iain McColl

How can our democracy ask us to do things that are contrary to everything we have spent our lives as health professionals trying to achieve?

Joan MacFarlane, treating asylum seekers in Sheffield, page 150

Fiddle playing, in moderation, is just about bearable

A Registrar writes, page 149

Investment in, and support of, both family planning services, and family planning training for primary care teams, is essential to reverse the trends of our current sexual health crisis

Deborah Lee, page 152

I have even met a balanced midwife ...

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contents

Learning and teaching about diversity

ASME meeting, 15 October 2003, Aston University, Birmingham

On a sunny autumnal morning, the Diversity Interest Group (DIG) launched its inaugural meeting. DIG comprises five medical teachers from around the UK who formed a group in 2001 to promote the teaching of diversity in the undergraduate medical curriculum. Their educational initiatives are underpinned by the current research, to which they also contribute. The aims of the ASME (Association for the Study of Medical Education) meeting were to look at the issues around diversity within an educational context and to share the current experience among participants.

As so often happens at educational meetings it is the students' contribution which enlivens the event, adding a freshness and authenticity to the day. Two groups of medical students, representing different cultural groups, from St George's, London and Birmingham Medical School, presented a selection of dramatic tableaux to illuminate some of the problems around cultural issues students experience at medical school. The students reminded us of the stereotyping and inaccurate assumptions that we have all used, with humour and irony.

The theatre was followed by a keynote address from Naaz Coker, Chair of the Refugee Council. Naaz painted the wider picture, covering the past 10 years of an often negative experience of 'racial awareness training'. Such programmes frequently see black people as 'other', a homogenous category which requires 'special treatment'. In reality, each individual, regardless of their ethnicity, has their own uniquely different story to tell. The common experiences any minority group of people share have more to do with the political context and the wider society in which they live, rather than personal similarities.

The tension between individual experience and the wider historical, political context was continued in a discussion led by Dr Iona Heath and Dr Mike Shooter. Iona challenged the basic premise of medical education which insists that all illness must be diagnosed and categorized. Her challenge to doctors is to 'interrogate all labels', which experience often tells us are meaningless.

Mike spoke from a personal perspective, reminding us that a mental health diagnosis also sets people apart. We are less likely to acknowledge a 'hidden' difference although it can result in a similar sense of alienation and exclusion. Mike's candid exposition of his individual stance, both as a patient and professional encouraged a more open discussion than sometimes occurs in academic meetings.

The morning's programme included two thoughtful presentations by medical students, Jamaal Khan and Emily Spry. They reminded us to look at students' own views on diversity and how a supportive Faculty can often contribute more than an imposed curriculum, which may be seen as irrelevant.

Dr Nisha Dogra concluded the morning with a presentation of a comprehensive overview of the current practice of teaching on human diversity, in 30 of the medical schools in the UK and Ireland. The results are the product of 1 year's work on the part of the DIG and will be available in the New Year. They present a detailed picture of a subject that is often included in undergraduate curricula but is fragmented, often hidden and subject to a myriad of assessment procedures. One of the most interesting findings is the mismatch between student and staff perspectives about what is actually included in curricula.

The afternoon was occupied with small group work. As with so many educational innovations the real work has to start with the educators, and there is much variance in how comfortable clinicians are at confronting the issues of diversity. These range from those who see the wider issues of differing human experience as beyond the remit of medical education, contrasted with a more open-minded view which accepts the challenge to examine one's own practice.

The day's programme closed with a plenary led by the inimitable Dr John Spencer. Among the conclusions drawn was recognition that other minority groups have already produced guidelines on good practice, endorsed by the General Medical Council. For example, GLADD (Gay and Lesbian Association of Doctors and Dentists) who were represented by Dr Rachel Hogg. In addition, a lack of reference to other healthcare professions, often more enlightened in their approach to cultural diversity, was acknowledged.

This challenging and emotive area, covered by the meeting, poses more questions than answers. The debate is likely to continue for a long time yet. There are often, however, more similarities between differing cultural groups than there are differences. I should like to close by paraphrasing the words of Naaz Coker who reminded us that there are fundamental desires in life which all human beings share. These are the desire for respect, recognition, access to adequate resources and representation. We have a long way to go.

Jane Roberts

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ASME: Association for the Study of Medical Education:
www.asme.org.uk

New RCGP publications

Obstetrics and Gynaecology in Primary Care
Edited by Manish Latthe, Sirjit S Bath and Pallavi M Latthe
RCGP, 2003
182 pp, £21.50 (£19.35 members)

Written by experienced clinicians, this manual for the typical consultations routinely encountered in general practice on a variety of obstetric and gynaecological conditions. It offers practical information on basic investigation and management strategies, outlining causes, investigations, diagnoses and treatment options using a symptom-based approach, provides guidance on practical prescribing and explores common misconceptions and pitfalls.

The authors have considered the physical, social, and psychological aspects of the disorders discussed.

Each chapter provides useful tips based on the authors' own experience accumulated over the years. Each chapter also provides information on where to find both clinician information and patient information/support groups on the internet with a list of useful websites.

Recommended reading for the DRCOG.

To order contact RCGP Sales:
Tel: 020 7823 9698 or
email: sales@rcgp.org.uk

DUE SPRING 2004

The Management Handbook for Primary Care
Edited by Tim Swanwick
RCGP, 2004
256pp

This is a handbook of management skills for general practitioners and other primary care workers who find themselves, perhaps unexpectedly, in management positions. The book, conceived during the 2002 RCGP Leadership Programme, focuses on useful techniques and methods for the day-to-day management of people, projects and organisations covering topics such as appraisal, organisational development, change management and team working. This is a skills-based book and after reading each chapter, the reader should have the confidence to 'have-a-go', or at least have developed an insight as to how things might go better next time!

flora medica theophrastus bombastus

From the journals, December 2003

***New Eng J Med* Vol 349**
2191 Virtual colonoscopy proved equal to the real thing in this study which screened average-risk patients for malignant and pre-malignant lesions. Unfortunately there is no such thing as virtual bowel preparation.
2316 Not all plaque rupture in the coronary arteries leads to catastrophe, but the chances of occlusion are higher if there has been bleeding into the plaque.
2387 If you want to avoid surgery for benign prostatic hypertrophy, go for two drugs rather than one: there was a dramatic reduction in interventions when finasteride was combined with doxazosin in this study.
2510 Cervical spine X-rays rarely reveal anything following neck trauma, so when might it be safe to omit them? Go for the Canadian C-spine rule rather than the NEXUS Low-Risk Criteria: it's safer.

***Lancet* Vol 362**
1867 Many GPs have trouble remembering the anatomy of the shoulder joint, but does an anatomical diagnosis of shoulder pain really matter? This editorial points out that the studies seem to show 70% improvement with injection whatever the mechanism, but little benefit from physiotherapy.
1883 In the UK, clinical examination misses the majority of congenital dislocation of the hip, whereas in this German study, universal ultrasound saved most babies from surgery.
1991 Community-acquired pneumonia may kill some of your patients this winter, so it's worth seeking out this review and remembering CURB — the danger signs of confusion, raised urea, raised respiratory rate, and low blood pressure.
2037 The best way to cope with the British winter is to take a flight to New Zealand (NZ), but you will double your chance of getting a deep vein thrombosis. This NZ study found several cases in low-risk individuals, whereas a German study in *Arch Intern Med* (**163:** 2759) found that everyone with clots had risk factors. Risk factors certainly are risky: an Italian study on page 2771 shows that oral contraception or thrombophilia give you a 15-fold risk if you fly.
But for *real* risk, practise surgery in Colombia (and win the **Bombastus Prize for Masterly Understatement, 2003**)...
2066 "Removal of unexploded missiles from live patients are rare events."
As in Liverpool, the trick is to wear lots of Kevlar®.

***JAMA* Vol 290**
2805 A recent meta-analysis of blood pressure lowering drugs in *The Lancet* showed an increase in heart failure with calcium channel blockers, but the INVEST study showed good results from verapamil — perhaps because most patients also took trandolapril.
2849 Pulmonary embolism can be excluded in low-risk patients who have low levels of D-dimer.
2952 Hypothyroid patients lack both T4 and T3 — so is it enough to replace just T4 (which we must now call levothyroxine)? Yes — this study shows no benefit from adding T3 (which we must now call liothyronine).
2959 A cohort study of bowel cancer in US veterans confirms a weak protective effect from dietary fibre, vitamin D and non-steroidal anti-inflammatory drugs.
3092 If you're unfit as a young adult, you're likely to stay that way into the dangerous years of late middle age.
3129 Those whose angina is brought on by sex may find that pre-coital nitroglycerine is dynamite in bed.
3183 Set a bug to kill a bug — a news item which heralds bacteriophage viruses as the answer to antibiotic-resistant bacteria.

Other Journals:
The SHEP study was one of the first to show that treating isolated systolic hypertension in the elderly is worthwhile, and 14-year follow up in ***Arch Intern Med*** (**163:** 2728) confirms this. A paper on page 2751 looks at 'spiritual behaviour' among US physicians: most would join a patient in prayer, if asked. A common dilemma in general practice is 'not-quite-typical' chest pain. Beware: studies conducted in emergency departments show that response to glyceryl trinitrate is not of any diagnostic value (*Ann Intern Med* **139:** 979) and 'indigestion' or burning retrosternal pain is often cardiac in origin (*QJM* **96:** 893). Thunderstorms in the Austrian Alps are wonderfully dramatic, but the psychiatrists of Innsbruck have noticed a disturbing trend for them to be followed by suicide — see *Acta Psychiatr Scand* (**108:** 455). However, when they did a literature review, they couldn't find any general associations between weather and suicide (page 402). Finally, a cautionary tale from *Arch Dis Child* (**88:** 1125). A 4-year-old on continuous intranasal home oxygen got too close to the cake while blowing out his birthday candles. Whoosh! But his sister saved him from more than frizzled hair and a sore nose.

Plant of the Month: *Garrya x issaquahensis* 'Glasnevin Wine'
This offspring of the municipal favourite, *Garrya elliptica*, is rumoured to have long catkins of attractive purple. But mine have all died before coming to flowering age.

My GP workload

LAST year during national general practice week, I heard a statement that it was difficult to demonstrate that GPs' workload had increased over the years. I, like my colleagues knew it had, but was there a simple way of showing it? When I joined my practice more than 20 years ago, I initially kept a log diary. I could compare a month of consultations starting in National General Practice week in 2002 with an equivalent month in 1982. We have changed from a practice of 5.5 w.t.e. (work time equivalent) to 7.5 w.t.e. GPs and our list has increased from 11 000 to 13 000.

The results were interesting. I do fewer surgery consultations and far fewer visits now. However, I do more surgeries and the standard surgery is 25 minutes longer. Therefore consultation times are significantly longer.

Table 1. Characteristics of consultations in 1982 and 2002.

	1982	2002
Patients seen in surgery (*n*)	381	363
Average age (years)	29	51
Patients visited (*n*)	103	40
Average age (years)	48	75
Total patients seen (*n*)	484	403
Average age (years)	33	53
Total number of surgeries (*n*)	29	36
Average duration (hours)	2	2.33
Total surgery time (hours)	58	84
Average surgery consultation length (mins)	9.1	13.9

My patients have aged with me, and at the same rate, since I was 31 years old in 1982. However if only the over-50-year-old patients are compared, then the results are surprising. The number of investigations is dramatically higher, and the number of problems per consultation has increased. Prescribing has stayed much the same while out-patient referral has increased significantly. The lower admission rate probably reflects that an out-of-hours organisation is responsible for 14 hours of care a day, and I have not included their figures.

Table 2. Consultations characteristics of those patients over 50 years of age in 1982 and 2002.

	1982	2002
Patients seen — surgery and visits (*n*)	153	237
Average number of diagnoses (*n*)	1.1	1.27
Total diagnoses made (*n*)	168	301
Average number of items prescribed (*n*)	0.84	0.84
Sick notes issued (*n* [%])	6 (3.8)	2 (0.8)
Investigations (*n* [%])	2 (1.3)	68(28.7)
Out-patient referral (*n* [%])	1 (0.7)	7 (3)
Hospital admissions (*n* [%])	3 (2)	1 (0.4)

Other interpretations of the data will exist, but these figures confirm to me that I work considerably harder than I did 20 years ago.

So I work harder. What about my income? In 1982, a partner's income was £33 200, and if increased by the average earnings index, it should be £105 000 20 years later. My latest income is over £20 000 less than this. Oh well, I'll pin my hopes on GMS2.

Orest Mulka

commentary

DR Lee's heartfelt plea for increased investment in family planning training is timely and appropriate although her solutions could be disputed (*See — **Family planning training for the primary care team: reversing the trends of 'sexual ill-health': 152-153***). The dissociation of family planning services from core general practice may have done more harm than good; perhaps it is time to use the money currently invested in a separate but parallel service to develop true comprehensive family planning services within the envelope of the primary care team.

All general practitioners must have an up-to-date working knowledge of current trends in family planning and those with the MRCGP qualification will have been tested in these areas; a look at the current exam syllabus on the RCGP website will confirm this fact.

The syllabus further delineates true generalist skills and communication requirements needed to achieve a successful consultation. That this expertise is needed is confirmed by Dr Lee's quoted statistics of a 2:1 ratio of patients coming to GPs versus family planning clinics.

It is true that the MRCGP family planning testing is currently not competency-based, although developments in the examination may allow some progress in this area. Not all GPs will wish to offer implants or coil fittings, but all patients should undoubtedly have access to these services. Those GPs with special interests in family planning must be delineated, encouraged, trained and revalidated and primary care trusts should see that such an identified cadre can provide the population needs within the practice setting, but it must be acknowledged that the vast majority of family planning requirements will be fulfilled by non-specialist GPs as part of the core service.

It is by improving the core service provision that we stand the greatest chance of reversing the trends of sexual ill health.

Peter Tate

graeme walker

The hazards of fiddling

I decided I wanted to be a doctor at the age of 12. That was when I accompanied my dad, also a doctor, on a round-the-world trip in order that he could attend a medical conference in New Zealand. I had a fun time, and naturally I thought to myself, 'if this is what doctors do, then that's the job for me'. If there was any less selfish motive behind my career intentions then it must have been at some deeply subconscious level.

The early years of medical school stimulated lots of curiosity for medicine, and for the medical sciences, as intellectual pursuits. I developed a scientific, mechanistic understanding of human beings as physical entities, made up of atoms and cells and tissues and organs, albeit with a few fuzzy mental and emotional characteristics tagged on. Motivation was strong, but still its basis was selfish, consisting mainly of a desire to understand; in the beginning, this understanding was mostly detached from real human experience.

I found a new hobby at university: traditional Scots fiddle playing ... but, one day, during my first year of medical school, I noticed a pain in my bowing arm. It was like a muscle strain, and it was exacerbated if I went swimming or while taking notes in lectures. I gave the fiddle a rest for a week or two, but the pain didn't go. I went to my GP, who also thought muscle strain and offered me reassurance and analgesia. Months went by, with no improvement. I had heard of 'repetitive strain injuries' in musicians, and that they were considered to be somewhat vague diagnoses and were difficult to treat. Probably this is what it must be, I thought. Another visit to the doctor, and my suspicions were confirmed; if fiddle playing makes it worse, then the only answer was to stop fiddle playing. Concurrently with this pain in the upper part of my arm, I had a pain in my wrist which seemed to get worse when I played reels too fast. The two seemed entirely unrelated at the time, and I don't think I even thought to mention the wrist pain to my GP.

I stopped playing for a while, but the pain gnawed on. The constant ache was there regardless of what I did, while the burning intensification seared down my arm in a variable pattern, sometimes even reaching the tips of my fingers. I had developed a notion that this must be some sort of repetitive strain phenomenon, and that I would just have to live with it; I lived with it for 3 years before seeking further help.

The diagnosis of thoracic outlet syndrome was made by a neurologist in the end. The treatment was physiotherapy, and while operations were sometimes considered, I was cautioned that surgical options were of highly questionable benefit. Physiotherapy seemed to help, a bit ... well, at least up until the point at which I was discharged from follow-up. Soon thereafter, I became aware of a niggling pain in my other arm, strangely reminiscent of something I had experienced before. That evening, I lay down on the floor and cried for the first time in years. Physiotherapy had been of limited help ... surgery was apparently useless ... and I was destined to be a bearer of chronic and progressive pain, in both arms, with no prospect of a cure.

Another 3 years passed before my first rib and scalene muscles were removed on the right side. It was from a friend who is a retired cardiovascular surgeon in the US that I heard a positive view on the value of surgery. Symptoms are now much improved on that side (although there is still considerable discomfort) and I have the option of similar surgery on the left side at some point in the future. Fiddle playing, in moderation, is just about bearable.

My friend in the US says that doing medicine is like being a member of the biggest club in the world. Wherever we look, there are fellow doctors, who think on the same wavelength and who provide us with access to unquantifiable amounts of expertise relating to the relief of human suffering and distress. I often wonder whether being a member of that club hastened or delayed the treatment I received: my professional contacts have been invaluable, but perhaps I suffered in silence for too long because, naively, I thought that if something was wrong then I should have been able to work out what it was by myself.

In some strange way, I am glad of the continuing pain and discomfort I still have on a daily basis, which fluctuates in intensity in each of my arms. It creates feelings of vulnerability and passivity which help keep me conscious of the difficulties involved in attaining real empathy with another, and which provide a kind of justification for the attention I give to looking after my own selfish interests.

Graeme Walker has recently completed pre-registration training, based in primary care. This is the first in an occasional series of articles, charting his course towards a full-time career as a GP.

Postcard 8 ... Seeking refuge

PERHAPS in our responses to refugees we see our true selves. To some asylum seekers are the lowest of the low, which cost the country dearly while contributing nothing. They are portrayed as scroungers by particular newspapers and accused of everything from importing disease to undermining our culture. However at another level the policy of dispersing asylum seekers away from the south east of England can be seen as part of the regeneration process of many of our northern towns and cities. A process that has created jobs and paid for the renovation of decrepit, unwanted properties.

In primary care, refugees can be exhausting (too much extreme need not enough resource) frustrating (so much pain, so hard to communicate) challenging (so many different expectations built on previous experiences in their own country) and awe inspiring (How did they survive? How would I have fared?).

For primary care services already under pressure the sudden arrival and constant, rapid flow of sick, desperate, extremely distressed people, many of whom cannot speak English, can cause chaos. This is exacerbated by the lack of experience in managing people whose injuries and distress are caused by extreme acts of violence, including torture. Equally asylum seekers themselves have widely differing experiences and expectations of health care. Add to this a lack of understanding of how the NHS works and poor access to interpreters and it is hardly surprising that asylum seekers have a hard time accessing mainstream primary care.

Across the country PMS practices have been established to provide initial care and support until the immigration authorities reach decisions. Sheffield Asylum Seeker Health PMS went live in October 2002 and like others went on a rapid and steep learning curve. However, we are gradually getting organised and delivering a good basic service despite the current political climate. New arrivals are registered, have initial health assessments, appropriate screening, provided with information on appropriate use of the NHS and cared for until a decision is reached about whether they can stay.

When they arrive some are physically ill. Many are suffering from stress-related symptoms such as headaches, body pain, nightmares and anxiety attacks. The majority are escaping from war zones and they have endured long and arduous journeys to reach safety. The challenges of delivering health care to such a diverse, vulnerable group of people are considerable.

The Asylum Health Team deals with physical illness and injury. That is relatively easy, although sharing bedrooms with complete strangers can make even simple infections like scabies hard to treat. Managing the emotional turmoil is far more difficult. Many people have post-traumatic stress, nightmares and anxiety attacks, again a challenge to treat when they are sharing rooms with others who also experience night terrors and may be from opposing factions in the same war.

How do we deal with cascading nightmares? We write numerous letters and reports explaining the health impact of their social situation. But requests are often turned down and so people continue to present to services that can do little more than listen sympathetically and sometimes prescribe sedatives to help them get through the night. How do we manage people who are hyper-aroused and have panic attacks when they hear an exhaust backfire? Relaxation tapes transcribed by our interpreters help. So does teaching people self-management of stress-related symptoms. Most important is the reassurance that this is a normal reaction to everything that has happened, that they are not going mad and that with time and stability things will improve.

Unfortunately their extreme distress is often exacerbated by a chaotic immigration process that sends letters in English to people who cannot speak, let alone read the language, and then 'fail their case' initially because they do not attend appointments often many miles from where they live. The bureaucracy involved in the asylum process literally drives people mad and consequently costs the health service dearly.

As a team we have learned to listen respectfully to horrific stories and to judge no one. We watch as many gain strength and learn English. And we reflect on what a positive contribution these people would make to Sheffield life. We have met doctors, nurses, teachers, journalists, shopkeepers, farmers, geologists, meteorologists, and many others wanting to contribute to this country. Parents' skills at managing their children in the most appalling circumstances can be awe-inspiring and help us understand the power of love in families and the reason why parents risked everything to give their children a chance of life.

However, as winter progresses we are becoming extremely concerned about the increasing numbers of 'failed' asylum seekers desperately turning to us for support. These are people who, months ago, arrived in Sheffield, often confused and disorientated having been 'dispersed' from their arrival port. Initially they were hopeful that they were engaging in a fair and transparent process. A process that would offer a safe place to recuperate from torture and abuse, from terror and starvation. A place to stay until it was safe to return home.

References

1. National Coalition of Anti-Deportation Campaigns. Judge rules — Section 55 decisions — lead to breach of Article 3 of Human Rights Convention. http://www.ncadc.org.uk/letters/newszine37/shelter.html (accessed 8 Jan 2003).

But now, as the months go by, we are seeing them fail to prove their cases for asylum and then have all support withdrawn. People are evicted from their properties, left without any financial support, and yet not allowed to work while they await deportation. We are directed to treat them only as 'immediate and necessary' cases or ask them to pay for their treatment. But what is the point of asking people for payment when they do not have any money for food?

They come to our clinic desperate. They beg us to help them persuade the government to look again at their case. They think we have some influence over the process. Their pleading for assistance leaves staff feeling hopeless and impotent.

They threaten self-harm and suicide. We talk to parents about not frightening their children with these threats. They tell us we should read the newspapers about their country — places like the Congo, Iraq, Iran, Zimbabwe and ask us if would we not kill ourselves if it meant our children could remain safe in the UK? Asylum teams across the country hear about the worst examples of humanity. We all ask ourselves 'what would we do in these situations? How would we survive the losses we hear about? Would we be victims or perpetrators in order to survive?

The term 'victims of torture' it is no longer an academic, sanitised term. Everyday we listen to vivid stories of rape, explicit details of torture, families decimated by war and inhumane actions. Meanwhile, in a parallel universe our fellow countrymen are subjected to the endless information demonising asylum seekers. We wonder which part of the country bogus asylum seekers go to. We seem overwhelmingly to receive desperate, injured, abused, tortured survivors who have escaped by whatever means they could.

Last week we found someone sleeping in the entrance to our clinic. Everyday he begged us to help him. All we could offer was the Cathedral breakfast and the soup kitchen, which are for homeless people. Sheffield does not have a night shelter — apparently we do not need one because the government's policy on rough sleeping has provided enough bed spaces. Unfortunately these bed spaces are not for failed, destitute asylum seekers.

As winter deepens we are constantly worried that someone will die on the streets or kill themselves in desperation. We and our colleagues around the country tell ourselves that there is nothing we can do, we have done all we can, and it is out of our hands. Unfortunately that does not help. Policy makers occasionally should be put on the front line and face the consequence of their policies. Instead it is teams like ours who feel the pain and the shame of government policies every day.

Clearly if people fail to persuade the Government of their case to remain in this country, and that process has been fair and transparent then they should be removed. Currently, however, people are neither removed nor supported. Their situation becomes inhumane. This policy leaves us desperately sad, confused and ashamed. How can our democracy ask us to do things that are contrary to everything we have spent our lives as health professionals trying to achieve?

Making people destitute in this way is surely a breach of human rights. Judge Justice Maurice Kay summed up an asylum seeker's situation recently as, 'a life so destitute that no civilised nation could tolerate it'.[1] Yet despite the unremitting political and press reports it is the amazing acts of humanity from asylum seekers themselves that inspire.

We meet people everyday who are incredibly brave, amazingly resourceful, well-educated, kind and generous human beings. Parents who are able to be attentive, appropriately supportive and loving with their children, despite having suffered terribly themselves. Children who are enhancing our education system through their commitment, hard work and desire to succeed now they have survived.

Community groups of asylum seekers who are willing to share what little they have with others, willing to give their time to listen and support others. Perhaps what we learn from our clients is that humanity survives in people despite the ignominies and degradations suffered both prior to arrival and in this country.

We live in hope that the experience of asylum seekers and of teams like ours will be heard. Maybe, one day, we will all come to see that asking health professionals to refuse treatment to the most destitute is iniquitous. That most of those seeking refuge have a huge amount to give Britain. And above all perhaps, that we as a society are the ones who stand to gain most from treating asylum seekers with care and respect.

Joan MacFarlane

Technology and the refugee

The dreams that define technology are often as much mythological as technical and a penchant for the grand vision and the hubristic stalks prediction about the future. So it is interesting to ask humbler questions. What technologies would help the asylum seeker? Is there software that might lessen hatred of strangers? How easy is it to write an e-mail in Somali? Or create a web page in Albanian? In short, what does technology have to offer the immigrant and those who serve them?

Windows® 2000 is available in 24 languages and Office 2000 in 20. But what about all those cultures that are so small or so poor there is no profit in customising Windows® to the local tongue? Can they join the world on their own terms or only courtesy of Microsoft® and English?

Open source software is produced by unpaid programmers working together because they are all passionate about creating a particular kind of software. And communities of open source programmers are busy going places that Microsoft® deems unprofitable. Localised open-source versions of Windows® are now available for free in 42 languages with a further 46 in the pipeline. And Mozilla, an open source web browser, now speaks 65 languages — again all for free courtesy of open source programmers.[1]

The dream of an end to Babel, the universal translating machine, is also quite advanced. Software that translates text to another written language is already good enough for straightforward tasks. And although current speech recognition and speech synthesis still fall short of our natural rhythms both are progressing fast. Speech-to-speech translation for the major languages is probably only 5–10 years away.

Meanwhile, despite what the US says, technologies of identification remain surprisingly elusive. Iris scans appeal to politicians, but if you're looking for one particular person in the 180 000 passing through Heathrow each day then a technique with 99.9% sensitivity would lead to 180 people being stopped of whom 179 would be false positives. We may all dream of being more secure, but a national ID card is unlikely to do the business for a while yet.

Paul Hodgkin

1. See for example www.gnome.org and www.kde.org and www.mozilla.org for details.

THE UK is currently suffering from an epidemic of 'sexual ill-health.' The total annual number of abortions performed in England and Wales continues to spiral upwards, with 186 274 legal abortions taking place in 2001, an overall increase of 5% since 1996.[1] Our teenage pregnancy rates are the highest in Europe.[2] In addition the work of genitourinary medicine (GUM) departments has doubled in the past 10 years.[3] These services are thus totally overwhelmed, in some areas patients are having to wait for 4 weeks to be seen for testing for sexually transmitted infections.[4] Professor Adler's *BMJ* editorial outlined the UK's gloomy position yet again and concluded that our sexual health services are 'in a shambles.'[5]

The publication of *The national strategy for sexual health and HIV*,[3] clearly sets out target skill levels and goals to be achieved to improve the nation's sexual health. However, the wheels of change are ever slow, with many primary care trusts still to put the targets of the Strategy on their agenda.[6]

The Office of National Statistics (ONS) survey in 2000 showed that 58% of women had consulted about family planning issues in the year 1999–2000, of whom 82% of patients visited their GP, and 35% visited a community family planning clinic; a ratio of greater than 2:1.[7] Most patients are therefore still choosing to visit their GP for reproductive healthcare advice and help. It is now accepted that patients need a choice of venue to attend regarding family planning. However, it would seem logical to look closely at the reproductive healthcare skills of GPs and practice nurses, as a key to a future of improved sexual health.

The Royal College of General Practitioners (RCGP) maintain that obtaining the Joint Committee for Postgraduate Training in General Practice (JCPTGP) and Membership of The Royal College of General Practitioners (MRCGP), is evidence of competence in family planning, but is this really the case?[8] Some GPs choose to take the Diploma of the Faculty of Family Planning (DFFP), issued by the Faculty of Family Planning and Reproductive Healthcare (FFP and RHC). Statistics on what percentage of GPs take this qualification are not published. GPs in training are indeed now obliged to go on the DFFP theory course, but there is no stipulation to complete the training by attending clinics for the practical component.

A Wessex survey demonstrated that GPs who hold family planning certificates offer a wider range of contraceptives than those who do not.[8] Moreover, the DFFP is competency-based, not purely knowledge-based. The syllabus was updated in 2002, in line with skills of level 1 of the sexual health Strategy, specifically to include a module on GUM. Family planning diplomats of the future, will be competent in key areas, such as sexual history taking and risk assessment, as well as the ability to perform a GUM screen on female patients. Notably, they will be trained to counsel, test, treat and refer patients for genital tract *Chlamydia trachomatis*, our most prevalent sexually transmitted infection.

Of those who do acquire the DFFP, it is not uncommon for GPs to lapse with their subscription (currently £65 per year) and, as a result, their certificates become invalid. Compared to other commonly held GP diplomas; e.g. Diploma of the Royal College of Obstetricians and Gynaecologists (DRCOG), and the Diploma of Child Health (DCH), the DFFP costs a similar amount to take, but is alone in asking diplomats to pay a yearly fee.

Training to fit intrauterine devices (IUDs) or subdermal implants (SDIs) is seen by the Faculty as extended training after DFFP, and certificates (Letter of Competence in Intrauterine Techniques and Letter of Competence in Subdermal Implants (LOC IUT/SDI), will not be issued by the Faculty unless the DFFP is in date. For some GPs this may mean paying a backlog of possibly several hundred pounds — clearly a marked disincentive to any GP learning specialist family planning skills. Keeping certificates up to date represents the only way the Faculty can ensure standards are being met. However, the cost of being a diplomat of the Faculty is a relatively modest fee, but the costs of revalidation in time, effort and money for the multi-skilled GPs are huge, and this may indeed be one skill they feel they have to lose. A small saving to the GP, perhaps a large cost to the nation.

The need for these certificates is not even firmly established. Some respected bodies, including the Medical Protection Society and local medical committees (LMCs), do not consider that holding in date Faculty of Family Planning certificates is mandatory (East Dorset LMC, personal communication 2003). They maintain that it is acceptable for the GP to undertake procedures like IUD/implant fitting, without LOC IUT/SDI, so long as a GP can demonstrate they have been trained to the same standard as those who do hold these certificates. If GPs are aware of this, it may leave them confused and unconfident; unlikely to suggest or fit a contraceptive method that could lead to litigation, unsure of whether to try to pursue training or accept their current level of clinical activity.

In major cities where large family planning services flourish, patients can be referred for

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coils and implant fitting within these services. However, in more rural areas, with less abundant family planning clinics, greater distances and poorer transport systems, both patients and medical staff find attending clinics difficult. Many sexual health consultations are opportunistic; much may be lost if patients need to be re-referred elsewhere.

Many small family planning services do not have specific IUD/implant clinics, meaning that obtaining training for nurses and doctors is almost impossible. Underfunding of family planning and clinic closures, coupled with the national emphasis on teenage consultations, (teenagers being an unlikely group for coil fittings), has further confounded the problem. Some doctors have waited up to 2 years for a place in a local clinic for IUD training, and have been forced to drive long distances to get this experience. The end result is difficulty for a patient obtaining their contraceptive of choice. An inability to obtain an emergency IUDs for example, especially for a teenager in a rural setting, may be catastrophic.

Nurse family planning training is also in difficulty. Courses are more expensive, require time taken out of the practice and necessitate locum nurse cover. Obtaining practical sessions because of the general lack of clinics for training again is very difficult. In Dorset for example, the nearest family planning courses are in Southampton, 40 miles away and cost £550–770 per module, with a limited number of funded places available. In reality, nurses are often delegated family planning duties in the practice, without proper training. Patient Group Directions, a legal stipulation for nurses without prescribing qualifications to issue any medication, are rare in primary care, and many nurses have not even been trained, for example, to use them to correctly issue vital emergency contraception.[9]

Health visitors have very little family planning training, and generally, neither do other practice staff including receptionists. Giving appropriate appointments and telephone advice has to be seen as a priority right across the primary care team. This situation extends to other agencies including NHS Direct.

The repeat abortion rate has been quoted as high as 26%.[10] In an audit of women attending for termination in Dorset, 18.3% were repeat aborters. This means that possibly one quarter to one fifth of women undergoing a termination of pregnancy, have been through the procedure at least once already, and are therefore undergoing their second, third, fourth or occasionally fifth procedure. By definition, unprotected sex carries risk of acquiring a sexually transmitted infection. Some studies have suggested a prevalence of genital tract chlamydial infection of 25% in those requesting a termination of pregnancy.[11] Is it thus surprising that we have the sexual ill-heath outlined above? How can we seek to influence these statistics and reverse these trends?

One fact is certain; women will not stop having sex. The only way we can seek to influence these repeat abortion statistics, is to support patients in the use of modern day contraceptives. Continuation rates with modern oral contraceptives have been reported during one year, to be only 40–60%,[12] and difficulty with other methods commonly result in unplanned pregnancies. The emphasis of use of barrier methods to prevent the spread of STIs may inadvertently have led to a reduction in the use of more effective methods.[13] One way forward surely has to be increased confidence from health professionals, and greater awareness by the general public, of the use of compliance free methods; IUDs, the Mirena® (Schering Health) intrauterine system (IUS) and subdermal contraceptive implants (Implanon® [Organon]), the very methods GPs are finding it difficult to get the training and experience to fit.

The copper IUD has proved itself to be a safe, effective reliable method, wrongly accused over the years of a number of errors, including pelvic inflammatory disease and ectopic pregnancies.[14] Intrauterine devices, (currently priced at approximately £9 each), offer long-term, cost-effective contraception, and strangely are used by only 5% of the UK population, compared to 50 million women in China.[15] Perhaps this paper sheds some light on the reasons why.

The contraceptive implant, Implanon, similarly has shown itself to be our most effective contraceptive, with a failure rate less than vasectomy, virtually no contraindications to use and excellent continuation rates (>90% in our family planning service). Implanon lends itself to use in numerous scenarios, but in particular it may be chosen with success as a method for a young women undergoing termination of pregnancy. Economic analysis has shown Implanon to give the greatest cost per protected year of any contraceptives.[16]

The Mirena IUS is a safe, supremely effective contraceptive tool, with high acceptability and good continuation rates. It is frequently not realised that as a contraceptive, it has a lower failure rate than female sterilisation.[17] Satisfaction with all these methods has been shown to be excellent, and it seems farcical that women are still finding it difficult to obtain them.

Funding issues abound. GPs can write a prescription for any of these methods, even though they may perhaps not be able to fit them, whereas in family planning clinics, there may frequently be a waiting list of several months due to lack of financial resources. In the case of the Mirena IUS sometimes patients have been caught in the crossfire of who should be paying for their coil, causing quite inadvertent and unwarranted distress. Any protests about cost can surely be silenced by the unacceptable costs to the nation of nearly 200 000 abortions performed last year. A Mirena IUS costs £89 per device and this lasts for 5 years; a first trimester NHS abortion costs more than 5 times this amount, in pure monetary terms alone.

Much is made of patient choice for contraceptives, but if an expensive method does not appear to suit, some patients have equally been distressed by the reluctance of the doctor to agree to remove it. Are we so obsessed by statistics like continuation rates that we have actually forgotten the patient, who has every right to request a contraceptive be removed at any time she pleases? Much of family planning will always be correct patient selection, counselling and support, but nevertheless, trial and error remains part of clinical practice.

In conclusion, to reverse the trends of the nation's 'sexual ill-health,' the issue of family planning training for the primary care team, badly need addressing. GPs and practice nurses need clear advice about training requirements, and help to obtain this training, with practical support and finance. Provision of training is a unique function of any family planning service, and there is a finite level, below which they cannot function efficiently in this their prime role. Investment in, and support of, both family planning services, and family planning training for primary care teams, is essential to reverse the trends of our current sexual health crisis.

Deborah J Lee

Competing interests:
The author has received remuneration from Schering Healthcare, Solvay Healthcare, Wyeth Pharmaeuticals, Janssen-Cilag and Organon for lecturing and training healthcare professionals.

New Columnists: Report

In the December issue I invited submissions for new columnists for the *BJGP*. The response has been simply fantastic, and hugely cheering. Choosing two 'winners' has been very difficult, although pleasurable. So in the finest traditions of editorial indecision, I have chosen three — **Dougall Jeffries** will write for us from the Scilly Isles, and **Olivier Wong** from Paris. (As we go to press, number 3 awaits security clearance, and will be revealed next month ...) Meanwhile, we print the best of the rest in this issue and the next. Very many thanks to everyone who has contributed, and there will be further opportunities for new writers next year.

Alec Logan

Stereotypes

ONE of the most satisfying diagnoses that we confer is that of scabies. This is not because it is especially difficult to diagnose (although we have all been caught out), but because of the reaction it generally elicits in our patients. The space of a few seconds displays a fascinating range of facial contortions that reveal a standard sequence of underlying thoughts: misinterpretation, disbelief, denial, anger and, finally, disgust. (Acceptance is some way along the line.) Anger because, 'it must have been that tramp from down the road that gave it to me (or rather, leads this doctor to think I've got it)'; and denial and disgust because, 'it's only dirty, common people that get scabies, isn't it?' These reactions are interesting, both because of the stereotype of the scabies carrier imposed by our culture, and because these patients obviously do not think that they conform to this stereotype, even when objective evidence might suggest otherwise.

Medical practice is full of stereotypes. In our discipline we grow up with the belief that GPs are 'nice', that surgeons are not, that our orthopaedic colleagues cannot communicate, that health visitors wear twin sets and pearls, and that midwives are a little deranged. When I aspired to a career in academic general practice, I grew a beard and bought a tweed jacket, already shapeless. Photographs taken during the latter part of my year as a registrar (or trainee, to use the patronising terminology of the age) present an ardently dishevelled and hirsute young man earnestly reading the *BMJ*. There are still some notable beards that enhance some of my academic colleagues, but more are clean-shaven and sharply-dressed, including some of the females. The myth of stereotype has been dispelled by professional experience. I recognize too that I am surrounded by charming surgeons and eloquent orthopods, know some GPs that I would rather not, and have even met a balanced midwife. From psychiatry days, I recall the entertainment provided by trying to distinguish between staff and patients simply by appearance and behaviour. Occasionally I was correct (the heavier smokers were the nurses), but more often stereotype misled. We must, therefore, beware of categorising people according to stereotype.

And yet, sometimes it works. We can predict a high proportion of the presenting complaints in any routine surgery by a simple survey of the waiting room. Whether it be an HRT or emergency contraception request, a COPD exacerbation, an alcohol or drug addiction, or a simple sick line, our patients' appearances often betray their needs. I recall from obstetrics the stereotype of the *Guardian* Reading Teacher (GRT), who attended labour ward with a long and demanding list of items to be included in their intrapartum care. These included incense, vegetarian examination gel, water birth and an intact vagina. Typically, GRTs ultimately required maximum intervention, including fetal scalp and uterine pressure monitoring, general anaesthetic and caesarean section, complicated by secondary haemorrhage. Of course, they were not necessarily teachers; nor did they all read the *Guardian*, but the outcome was generally the same.

Other stereotypes inform clinical care, and this is where epidemiology comes in. At a population level, research tells us that certain characteristics are associated with certain outcomes, and this gives scientific confirmation of stereotypes. We know that the overweight, diabetic male smoker clutching a bag of chips is a typical 'heart attack waiting to happen', and we are correct to attempt to change those characteristics that render him so. That is, assuming he is our patient, and not the man sitting next to us at the football match. We know that people who live in deprived circumstances, who are unsupported or unable to work, and who are not well educated are at greater risk of most chronic diseases, and we are correct to agitate for anything that might improve their lot. However, epidemiology, and therefore stereotype, can only work at a population level. It cannot tell me that the slim, fit young woman in my surgery will not have an MI, nor that the next unemployed smoker with IHD is incapable of healthy self-improvement. It cannot predict my surprise at the identity of the positive gonococcus case. It cannot even assure me that I will not personally fall victim to scabies, despite my undoubtedly high standard of personal hygiene (*Sarcoptes scabei* eschews stereotype). For this information, we need to know and understand the individual, and this is what GPs are good at. At least, that is the stereotype we hold.

Blair H Smith

Rocking

DO you remember letters? As a child I was encouraged to foster pen-friends. For several years I corresponded with a girl in France and another in the US, enthusiastically at first, and then later rather half-heartedly, until eventually the exchanges dwindled to a trickle and dried up. In my early years at university, before the advent of electronic communication and a mobile phone in every pocket, letters from home and friends were a source of immense pleasure; the thrill of familiar handwriting on an envelope in the pigeon hole could brighten the gloomiest day.

These days it seems letters are reserved for Christmas, the relentlessly upbeat, 'round robin' variety that carry news of academic triumph or musical genius with the same glossy cheerfulness that accompanies tidings of cancer, death or divorce. Like most people, I suspect, I have a very

ambivalent relationship with this sort of communication, genuinely enjoying news from cherished old friends, but inwardly cringing at sending out a similar missive, allowing my husband to do the deed and sheepishly adding my monogram at the end.

I have recently, however, acquired a real and genuine pen-friend, as a direct result of an essay published in this Journal in 2002. Some weeks after publication I received, among others, a forwarded letter, handwritten, that immediately grabbed my attention. The writer was clearly well travelled, learned, and, most impressively, still reading the *BJGP* with a critical eye, at over 90 years of age. He is a founder member of the College, much travelled, having worked in India, Nepal and Greece (that I know of, possibly more), and we have become regular correspondents. His handwriting is clear and legible, his observations and comments wise, illuminating and entertaining.

In one of his latest letters he came up with the following gem, which I shall reproduce verbatim as it cannot be bettered:

'Recently, it occurred to me that some years ago, elderly persons were often deposited on a veranda (especially in the US) or by the kitchen fire, sitting in a Rocking Chair. I happened to be sitting by a window in one at the time. I have moved it near the fire, opposite my TV where I read or watch TV in the evenings. I rock slightly almost unconsciously fairly frequently and can feel my muscles from toes to thighs pumping fluids up to the body. Result: much less pitting oedema of my feet, ankles, etc.

If you are able to persuade some of your old people to Rock (and Roll) instead of sitting around rooms in old people's homes I should be interested to hear of the results. The problem may be to get hold of suitable chairs. I think fairly heavy upright (Windsor?) ones with a minimum movement may be best.'

So simple, so elegant and, probably, so right. A significant proportion of requests for visits to nursing homes are for the reported problem of 'swollen ankles', often accompanied by a request for a prescription for diuretics. The exhortation to elevate the legs seems to have minimal impact, and probably encourages immobility. I have seen some places introduce aerobics classes for residents, with photographs of aged limbs wildly flailing proudly displayed on the notice board by the entrance. But rocking seems so obvious, so automatic, so ... pleasant. How to disseminate the message? I tried the suggestion on an elderly widow who still manages to struggle up the long flight of stairs to my back-landing consulting room, but who is troubled by substantial oedema. She grinned, reporting that she had got rid of her husband's rocking chair after he died, much to the annoyance of the rest of the family. Her physiotherapist had told her to buy a radiator paint roller and use it to massage the legs in an upward direction. It helps a little, she said. Both she and her daughter who accompanies her to make sure she doesn't fall on her way back down the stairs, thought the rocking an excellent idea. Certainly, they conceded, it sounds less eccentric than a paint roller. I think they were headed straight off to Chairs R Us to begin the search for the ideal rocker.

So, readers of this column (I know there is at least one retired GP), please pass on the good news. Perhaps between us we can have a nation of old folk rocking (and rolling), and save the NHS a (small) fortune in frusemide (and the consequent incontinence pads), as well as perhaps reducing the incidence of DVT. I wonder if anyone academically inclined is interested in designing a study to evaluate the evidence?

Wendy-Jane Walton

Saying no

I was intrigued that recent interrogation of an affable internet search engine yielded over 1 million entries regarding the subject of 'saying yes'. However, entries pertaining to 'saying no' exceeded 3 million. How should this be interpreted?

Are those with an interest in saying no in greater need of help, of accessing those anonymous support mechanisms available online: understanding, supportive chat room opinion, psychological validation, counselling services, positions vacant, personal body guards …?

Searching further would empower you to say no in a multitude of ways, verbal or non, but this would little diminish the discomfort we often feel when faced with the need to decline a proposal. It is usually more illuminating to consider the meaning implied in the refusal. (Surely we in general practice must be getting good at this by now.)

For example:

No. I'm lazy and can't be bothered.
No. I have no interest in your proposal.
No. I don't like you.
No. I am not sure this proposal marries with my agenda. What is your agenda?
No. I am not clear that you have cleared this commitment with my wife/ husband/ partner/ partners/ child/ children/ important others/ bowling team/ golf club (as if) …
No. What are the arrangements to remunerate my time/ money/ locum fees? Who is the locum?
No. I have had no reason to believe, given past experience, that devoting any energy to this domain will result in any tangible product/ progress.
No. You do not seem to have the tools at your disposal to let me understand the benefits to my patients or me and why therefore energy should be expended in this area.
No. I am already working at 110% and though I am mildly fond of the ground on which you walk I still must do all I can to prevent commitment overload.
No. Saying no will enable me to concentrate on the areas that I am proficient in and will maintain standards.
No. I suspect your proposal is a superficial number-crunching exercise and that there is an ulterior motive.
No. I can do anything, but not everything. Each day I carry seven monkeys on my back and can only carry seven. If you want me to carry your monkey which of my monkeys will you carry in return?
No. My reasons are not your concern.

Who can we look to for guidance?

The terrible twos have it right. Do we not admire the natural default state of the young unencumbered human debutante — their role, to say 'No', in a clear firm voice, with steady guilt-free eye contact, backed by the unity of their peers, exploring their world and defining boundaries with a healthy defiance? No?

Those involved in the negotiation of the new GP contract are to be congratulated — no doubt faced at every turn with the consideration of saying No. I would commend their achievements to date and the manner in which they have consulted and informed their peers.

Key to these developments must be the act of saying No gaining acceptance — as a means of defending standards of care, of maintaining safe practice, achieving quality markers within budget constraints, and tackling those issues of professional longevity and retention.

It must be seen to be acceptable to opt out of providing some services understanding that this course of action supports the care provided for patients and the quality of life for doctors.

And while my head acknowledges with relief the logic in this change, somewhere in my heart I am still struggling to come to terms with my position as an old fogey battling with the unsustainable commitment, and the voting on their feet of my successors and colleagues who whisper:

'I told you so'.

What is it like for you?

Of course, should these musings lead to the opportunity to undertake any public speaking — I'll think about it.

David Connell

Workout with words — a poetry project in a GP surgery

THE idea came from a patient. At the beginning of a consultation she nervously recited a poem, by Lynn New, found on a fridge magnet. She told me she had practised it on the bus on the way to the surgery, and again when she was sitting in the waiting room.

> *'I'm having a nervous breakdown*
> *I can feel it coming on*
> *I can't see reason any more*
> *And my hope is all gone ...*
> *Some say I'm neurotic*
> *But that is not the case.*
> *I don't need a psychiatrist…*
> *I just need my own space.'*

Although the poem may not have great literary value, it seemed to be something in her confused and chaotic life that made sense. She wasn't having a nervous breakdown, it was a little more space that she needed and even if, with five young children, she couldn't have it, somehow she could have the poem and that was a start.

Creative writing has been used in various health settings, particularly in terminal care, psychiatry, primary care, and rehabilitation.[1-4] However, we know of only one other project involving a poet in residence in a GP surgery.[5] There is some evidence to suggest that writing poetry may be effective in reducing stress and promoting wellbeing.[6-8]

We devised a project that was funded by Gloucestershire Adult Continuing Education and Training. Patients and staff were invited to attend creative writing sessions in the surgery with EW, individually or in groups. Some were referred by health staff, others self-referred. There was also a weekly group workshop for staff only which ran for 10 weeks. Printed poems and poem leaflets were available in the waiting room for patients to take away (Poems in the Waiting Room, Lee M [ed], 1998), and a collection of framed poems[9] displayed throughout the surgery building. To complete the project we have had printed a collection of 50 poems written by staff and patients.[10]

Initially, the project was viewed with suspicion. It was felt by some not to be proper medicine, a waste of time and money, transient, trendy. Slowly, though, poetry began to surround and inform us. Those who attended surprised themselves with what they wrote. The weekly staff workshops were well attended and invigorating.

Having a poet in the practice changed a few people's lives. We are used to drugs and therapies that help a large number of people in a small way. It is difficult to be sure what, exactly, benefit means. An improvement in their writing skills perhaps, or a clearer understanding of themselves, or just becoming a little happier and gaining some self-esteem. All important things seem so difficult to measure.

All participants completed a questionnaire. Including staff, 21 women and 4 men attended between one and eight writing sessions, each lasting about an hour. Participants' ages ranged from 25–75 years. Nine had never written poetry before; only four had done so recently. Some were suffering from depression or adjusting to life changes, some had chronic health problems, others were just interested and keen to try a different creative activity. However, many participants commented on the stress-relieving benefits of taking part: 'I was astonished at the volume and depth of emotion that came out in words', 'felt very relaxed after the session; it was a great stress reliever', 'a great way of sharing within the group'. Several perceived the writing process as therapeutic in some way: 'It's like taking the lid off!' 'It unlocked something I didn't know was there'.

One patient, particularly, seemed to benefit a great deal. She is 33 years old, had a serious head injury as a child and has multiple problems. She attends frequently with numerous medically unexplained symptoms. During the poetry project her consultation rate dropped dramatically, and she began to shape her feelings and experience into poems:

> ***Jigsaws***
> *Jigsaws are*
> *Interesting to do but*
> *Generally one piece lost under*
> *Something*
> *And never made*
> *Whole.*[10]

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Lost
My ambition to be a nurse
My confidence
Front door key
ME
My taste and smell
Without my Dad
Friends
To be able to read a book all the way through
Shopping in a big store
My purse
My favourite film (Mike had taped me)
My jewellery
My way
My best pen.[10]

S Hayward

I, in turn, had to re-examine my view of her. Through many years of seeing her, I had lost sight of her own unique humanity and had become incapable of giving her the respect that I owed her.

We have to start promoting non-medical therapies for non-medical problems. Every time we prescribe, when there is no true medical problem, we are conspiring to medicalise. Poetry does not cure disease. Neither does diazepam bring back the lover who has left, the mother who has died. Poetry is about something that you didn't quite know was there. It is the process of writing that can surprise you and be uplifting. It makes you feel better.

The poetry project lasted 3 months. My patient has now been befriended by other participants of our poetry sessions. They phone her up, drive to her village to collect her and together they go to writing workshops. This may not seem like much, but for her it is incredible. She comes to see me sometimes and I am determined not to medicalise her life. Often we talk about writing and poetry. But sometimes it is just so tempting to bang out a prescription for her complaints and move onto the next patient.

Perhaps next time, instead of the antibiotics, or the Patient Information leaflets, I should just choose an appropriate poem and print that out on an FP10.

It might do less harm, and who knows ...

Simon Opher
Emily Wills

Consent
Full consent for the use of all material in this article was gained from the patient prior to publication.

Poetry therapy: theory and practice
Nicholas Mazza
Brunner-Routledge; London, 2003
PB, 240 pp, £16.95 (0 415 94486 4)
Doorways — Poems from May Lane Surgery
Published by May Lane Surgery, Dursley, Glos, GL11 4JN, 2003

EXPRESSIVE, explorative writing is a powerful way of dealing with pain, anxiety, bereavement, and chronic, terminal or acute illness. When we enter such states we have crossed a boundary away from a healthy, secure, confident life; we need something to hang onto, something as a guide. It is also a way of expressing deep joy, and of reconnecting oneself with younger selves, as in happy childhood memories. Writing can be a lodestone: pointing us to the true north. Many of the issues to be faced are known; but often the most troubling, or unstable-making are unknown. Writing is a quick, straightforward way to get in touch with such areas.

Poetry writing is particularly good, like Spike Milligan's *String*: 'Rope is thicker,/ but string/ is quicker.' Poetry is short, to the point and is capable of capturing, seemingly from nowhere, issues which we most need to think about. Why else do so many people only write poetry at a time of birth, bereavement or passionate intense love? Patients can be encouraged to write helpfully and joyously at other times also.

Nick Mazza's *Poetry Therapy* is a handbook for anyone involved in therapeutic relationships, or just interested in doing it. The focus in poetry therapy is upon the person and not the poem; writers are not expected to write finished pieces such as one might read in a book. It's the process which matters, not the product. Although the product often brings a sense of achievement and self-worth, and can be appreciated by others.

The theoretical background is of interest to those involved in counselling. There are, usefully, some very straightforward ideas for using writing with patients, particularly in the family therapy chapter, such as creating a list beginning with: 'I am afraid of …' 'I feel loved when …'. Lists, in my experience, are wonderful things — they can lead to so much, and yet anyone can write a list. There are also valuable suggestions for patients reading published poems, such as, *To everything there is a season* from Ecclesiastes.

Poems from May Lane Surgery is a delightful collection created by poet, patients and staff. They range from *I remember* by K Curtis-Hayward, to *Jigsaws* by S Hayward. Every GP surgery needs a poet, or at least the encouragement to write. How about practice poets, as well as practice nurses?

Gillie Bolton

Poems in the Waiting Room

Arts Council England has awarded a Lottery funded grant to expand *Poems in the Waiting Room*. The service, which has been running since 1998, supplies free poetry pamphlets in health service waiting rooms for patients to keep. It is highly popular with patients. One wrote: '*What a really lovely idea! Thank you very much for lighting up our doctor's surgery waiting room. The day's weather was awful! The atmosphere in the waiting room none too healthy. But your poems are all wonderful — and meaningful. Well done and thanks.*'

At first, distribution was confined to South West London but soon spread, with practices recruited mainly by word of mouth. Expansion became demand-led, straining the original sponsor The Beatrice Trust's budget.

The Arts Council grant now opens the chance for all primary care practices to benefit from the service. *Poems in the Waiting Room* has circulated NHS Primary Care Trusts as a means to inform each general practice of this opportunity.

The scheme is a registered charity (1099033), and no charge whatsoever is made for the poetry pamphlets. The sole obligation is to put them on display.

For samples of the poetry pamphlets and further information contact:

Michael Lee,
Editor, *Poems in the Waiting Room*
pitwr@blueyonder.co.uk or
34 Beechwood Avenue, Richmond TW9 4DE, Tel 020 8876 4379.

All the Ethels

AFTER morning surgery I trudged down the corridor to pick up the patient records. It was almost a perfect day — only one visit and this just a few metres from the surgery doors in an adjacent tower block.

Ethel, whom I had only met once before, had called for a visit, because she was, according to the carefully transcribed message, dizzy. She had recently had a TIA, and so I strode with greater purpose than I might otherwise have done towards her draughty home.

The intercom was out of order, but I managed to gain entry to the block by ringing number 50 and speaking apologetically and politely with my head turned plaintively towards the camera. This is an old method employed by GPs and vagabonds the length and breadth of the land. It has rarely failed me in Bethnal Green.

The lift squeaked to a stand at the thirteenth floor in a reek of chlorine with the numbers approaching treble figures. Windows at each end of the corridor framed views of the Hampstead Hills and the North Downs. I am always drawn to these or similar images and find myself briefly lost in fantasies that take me back and forwards in time.

I failed to gain access after several attempts. As my knocks became louder, my curses remained resolutely inaudible. That day my demons were in check, so rather than turning on my heel as I would have preferred, I answered the voice somewhere in my head that was gently suggesting that I follow this one through. There were eight doors on her landing each protected by a steel gate bolted into the masonry, and at each one I drew no response. Glancing back at the framed views northwest and southeast I again saw distant rising ground and thought of other things.

In the basement I found the caretakers. Just inside an open door were two men in blue overalls, their feet up watching the racing on a small screen. There was the sweet smell of rolled tobacco burning. There were no audible complaints as they led me down to the neighbourhood office, less than 50 yards away. An elderly woman in distress is sacred even when the 2.15 is about to run at Chepstow.

It took a while to rouse out the neighbourhood carpenter, a man I had never met before. He was not grouchy, red-eyed or ruffled, but a moderately business-like, brown boiler-suited, middle-aged fellow with a pink face. With his tool bag in hand he silently joined the convoy back to the block.

I stood and chatted with the caretakers while the carpenter hammered the steel gate free. For a while I wrestled with the concept of a carpenter forcibly removing metal from masonry and concluded that like GPs they probably have a wide remit. It took about 20 minutes and was audible throughout the block. Despite this we remained undisturbed. The gate finally came away, and then the door with no more than a nudge from the booted foot of our neighbourhood man.

Of course the flat was empty. Out in the corridor, as I was facing the three men with a mounting embarrassment, the door opposite slowly opened and a timid cockney voice informed us that Ethel had gone ‘down the club’ about an hour ago and was expected back later. Sensing that the pendulum of stupidity had swung away from me, I made my exit with as much charm as I could muster and headed back to the surgery.

I was deeply irritated by this turn of events and, questioning the wisdom of my involvement in primary care at any level, I burrowed back into the paperwork I should already have been enjoying.

Some time passed before one of the receptionists stuck her head round the door and said, ‘We’ve done a computer search for all the Ethels, rung them up, and not one of them’s requested a visit today.’ I was hugely impressed by their spontaneous ingenuity, motivation and determination.

When Ethel rang the surgery she said, ‘I just wanted to say thanks for caring enough to do what you did.’ She was calm about her absent door and gate, but eager to explain that she hadn’t in fact requested a visit at all, only an appointment for later in the week.

I never did discover who was responsible for the transmutation of that appointment, but the receptionists knew there had been a transcription error and had done their best to make amends.

Jim Hardy

news

THE RCGP's Honorary Secretary, Dr Maureen Baker, is to be awarded a CBE for services to medicine.

Dr Baker has been in her role at the RCGP since 1999 and is also the Director of Primary Care at the National Patient Safety Agency. She was previously a GP in Lincolnshire and an associate adviser and lecturer in General Practice at Nottingham University. In 2003, she oversaw the College's written evidence for the Inquiry into the death of Victoria Climbié.

Her main research interests are medical workforce and careers with much of her work being published in peer-reviewed journals. In 2000 she co-wrote *A guide to general practice careers* with Professor Ruth Chambers, and in the same year *Is there a future for independent contractor status in UK general practice?* with Professor Mike Pringle. Dr Baker has also sat on many working parties including the National Consultative Group for PMS Pilots and the National Development Group for GPs with a Special Interest.

Dr Baker graduated from Dundee University Medical School in 1981 and is married with two daughters.

diary

19 February
Scolty Residential Course
Raemoir House Hotel, Aberdeenshire
Contact: Amanda Slorach
E-mail: rcgp@grampian.scot.nhs.uk
Tel: 01224 558044

19 February
Education — Partners in Practice 2004
Herons' Reach De Vere Hotel, Blackpool
Contact: Victoria Langley
E-mail: education@rcn.org.uk
Tel: 020 7647 3579

19 February
Acute Primary Care Issues in Patients with Significant Learning Disabilities
The Hilton Hotel, Coventry
Contact: Claire Aberdeen
E-mail: claire@compass-healthcare.co.uk
Tel: 01628 510 183

24 February
NPSA Patient Safety 2004 Conference
ICC, Birmingham
Contact: Patient Safety Team
E-mail: PatientSafety2004@mci-group.com
Tel: 0870 458 4124

24 February
Coaching Workshop for GP's
Frenchay Centre for Medical Education, Bristol
Contact: Elaine Smith
E-mail: events@inanyevent-uk.com
Tel: 0117 925 7100

28 February
MRCGP Video Skills Consultation Preparation Course
Hanover International Hotel, Warrington
Contact: Anna Reid
E-mail: mersey@rcgp.org.uk
Tel: 0151 708 0865

3 March
Breast Cancer — Recognition and Referral
RCGP, Princes Gate, London
Contact: Georgina Brodie
E-mail: georgina.brodie@rsm.ac.uk
Tel: 020 7290 3856

4 March
Quality Outcomes for new GMS and PMS
QE2 Centre, London
Contact: Sandra Barradas
E-mail: s.barradas@ihm.org.uk
Tel: 020 7881 3291

8 March
'Towards Even Better General Practice' Course'
Cumberland Lodge, Windsor
Contact: Sue Daniel
E-mail: tvalley@rcgp.org.uk
Tel: 01628 674014

neville goodman

Kan u spel?

SOME people can spell; some can't. Intelligence, as conventionally assessed, is a factor but not exclusively: there are many highly intelligent people who can't spell. Nor is it primarily determined by how early in life one started to read, or how voraciously one read then or now. I had a highly intelligent lecturer working with me who started reading at some ridiculously early age. His draft papers were full of spelling mistakes, with many of the predictable ones, such as neccessary and seperate. Spell-checkers have helped those unable to spell, and I've had to turn it off to be able to write this article at all.

I'll also have to hope that I'm not sabotaged by over-keen editing. The ability to spell is obviously necessary to a proof-reader, but the ability to spot an error in type is not the same as the ability to spell. Spelling mistakes are the easiest of errors that proof-readers have to spot. They are easy to miss if one reads the piece in context, which allows the eye to take in the meaning of blocks of words without looking properly word by word: without prompting, not everyone would notice the extra 's' in misssion impossible. But by the same token, if I write that neccessary is a mis-spelling, the error will be corrected unless the text is read in context.

I've been a proof-reader since grammar school — where my spotting of the missing 'l' in a school magazine essay about the Viennese public transport system saved the school a deal of embarrassment (not an easy word to spell) and gained me a school prize (I did read the entire magazine proofs for 3 years). Proof-readers take spelling errors for granted; it is the more subtle ones they get joy from. I've always liked 'replace damaged character' — spotting, for example, that the descender of a 'g' was partly missing; electronic printing has made this far less common. I delighted in noticing $C0_2$ on our anaesthetic charts: that 0 (zero) should be an O (letter O).

Many drug names are mis-spelt: 10% of all papers indexed in Medline spell gentamicin gentamycin, and amitriptyline is spelt just about any way possible. The commonest mis-spelling in medical notes in hospital is probably vomiting, which gets a random scattering of double consonants more often than not. So as a service to British medicine, here is a brief statement of the doubling rule: the final consonant doubles if the last syllable is stressed (fitting but vomiting; people are balloted; kidneys are ballotted), but there are exceptions (paralleled). There are always exceptions.

candlelit contributors

There's only one **Gillie Bolton**!
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David Connell still sees 'RURAL ID ILL' as coming fairly close to his mental state. He is now fairly confident with any guitar chord starting with 'A', and remains passionate about general practice, while we still want him. **dg.connell@virgin.net**

Deborah Lee is an associate specialist in Reproductive Healthcare at Southampton Contraception & Sexual Health Services, The Quays to Health, Southampton — a very postmodern, 21st Century NHS address. 'The Quays to Health' — Gettit!! How clever is that.
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Joan MacFarlane is a nurse consultant in Sheffield and leads the Sheffield asylum team.
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Iain McColl is a GP in Glasgow, likes wine and rare cask-strength malts, plays a bit of golf, travels, sails, hunts rabbits and collects old English roses. He re-accredited your Dep Ed's training practice, which, like sitting next to him on budget airlines, is a sure route to publication in the *BJGP*.
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Graeme Walker is currently learning about primary care in south India, on a 6-week educational secondment as part of Scotland's new experimental GP training programme. **graemewalker@mac.com**

Wendy-Jane is a GP and a fell runner in Shrewsbury, and like Madonna, affects to discard her surname. It's Walton, for those of you still interested.
wendy-jane@doctors.org.uk

Emily Wills is a GP in Gloucestershire and writes poetry

jill thistlethwaite

The first surgery in Queensland

'Do you have to sign this?'

The patient had already signed her Medicare slip, entitling her to a free consultation as she was a student, but I wasn't sure about the cervical, or rather pap, smear request form. Luckily she knew and I managed to negotiate another bureaucratic difference: pathology forms need the patient's signature.

This was my first general practice session in Australia. New computer system, new office and not a single known patient. I was beginning to understand the healthcare system and which patients were charged for what. My interest now was to see if the presenting complaints were culturally sensitive. I had 15 minutes as standard per patient, as did the other doctors in the health centre. Fourteen minutes to tackle the problem and one minute to sort out the paperwork, I hoped.

My first visitor was the most clinically challenging. A case of right upper quadrant pain in a 23-year-old woman who had had a cholecystectomy several years previously. She wasn't jaundiced and her temperature was normal. It was obvious she wasn't looking for analgesia, although the thought crossed my mind. The history, examination and explanation took the full 15 minutes. I fell back onto one of the strategies for coping with uncertainty and asked her to come back the next day, albeit that would be to see another doctor. Great for me: a second opinion and someone who would know where to refer if that was needed. Moreover, as a person on a low income she was exempt from charges too, so another consultation was acceptable.

We both decided she needed a medical certificate. I asked her if she could sign herself off. She looked surprised. Obviously not then. I explained that patients in the UK could self-certificate. 'But doesn't everybody take days off work all the time?' I didn't want to start a sociological discussion, so loaded the headed notepaper into the printer and produced an A4-sized certificate, which looked distinctly unofficial. She was happy though.

The next patient had come for his second hepatitis B injection. Rules state that he had to see me first before the nurse could administer the vaccine. This also holds true for patients requiring a change of dressing, although such a strange overlap of responsibility may be reviewed in the New Year.

I explained to everyone that this was my first day. A young guy wanted to know how long I had been qualified! I was interested to see that almost all oral contraception comes in the ED form. Is this a marketing ploy or is there something about Australian females that makes them desire seven dummy pills a month?

Drug names are different. There is nothing resembling the BNF so MIMS has to do. Just before a prescription is printed, a pharmaceutical advert pops up on the VDU, but I usually don't know what it is for. All the medicines are coded as to whether they are permitted in sport. Well the population does seem to be divided into the ultra fit and the rather fat.

Speaking of sport there seems to be little ill feeling about the result of the Rugby World Cup final. Rugby is football and football is soccer, and Australian Rules is really not that popular in Queensland. I am ignorant of so many things, but perhaps not so ill informed as the young woman who wanted to have a yellow fever jab before she travelled to the UK.

Australian GPs are worried about money; medical indemnity is going through a crisis and there is a shortage of doctors. Not much change there then!