The Back Pages

viewpoint

Cot deaths: tragedy, suspicion and murder

I have taken a passing interest in the subject of cot death for some 30 years. Before starting at medical school, I spent part of what would now be called a 'gap year' working in the pathology department at the Children's Hospital in Sheffield. One of my jobs was to assist at postmortems, carried out by Professor John Emery, on babies thought to be cases of cot death. In the course of the current furore over the role of the eminent paediatrician, Professor Sir Roy Meadow, in a series of court cases involving mothers accused of killing their babies, I have often recalled how shocked I was when one day, Emery said that he believed that a significant proportion of babies thought to be cot deaths had in fact been killed by their parents.

In the early 1980s, Emery stated publicly that he estimated that 10% of deaths attributed to 'sudden infant death syndrome' (SIDS) were cases of filicide.[1,2] As cases of SIDS resulting from natural causes fell sharply in the 1990s (a trend widely attributed to the 'Back to Sleep' campaign), the proportion attributable to filicide would be expected to rise. In 1999 Michael Green, Emery's successor in Sheffield, indicated that 'in private conversation' pathologists estimated that between 20% and 40% of SIDS cases were homicides.[3]

In his 1999 paper 'Unnatural sudden infant death', Meadow surveyed 81 children who had been killed by their parents, identifying features that distinguished between natural and unnatural deaths.[4] Emery indicated in a letter that: 'the most usual scenario for filicide is for the baby to have been suffocated by an exhausted parent (usually the mother) while trying to quieten his or her crying'.[5] He believed that: 'these parents usually barely knew what they were doing and did not intend or want to kill their child.' (Sadly, in May 2000, a few weeks after this letter was published, John Emery died at the age of 84 years, trying to rescue his Airedale terrier from a house fire.[6])

As a leading expert witness, Meadow has become a prominent public advocate for the greater recognition of filicide. But it is one thing for doctors to indulge in private speculation about the proportion of SIDS cases that may be murder, quite another to present such estimates in public as though they were facts. Given the prevailing mistrust of parents, the public has become predisposed to the idea that all forms of child abuse — including murder — are much more common than was previously believed. Although the evidence of child abuse in any particular case may be weak and contested, Meadow's advocacy has tilted the scales of justice against the accused parent.

There are two extreme positions in the Meadow controversy. While some suspect that all parents may turn out to be child killers, others believe that all parents accused of child abuse are innocent. Although both positions are irrational, the former is more insidious because it currently enjoys the backing of the government, the professions of medicine, law and social work, and influential voluntary organisations. The most striking defect of the 'all parents are innocent' position is that, in its obvious absurdity, it does not provide the basis for effective resistance to the dominant trend for exaggerating the scale of human depravity in intimate relationships to justify further professional intervention.

It is understandable that parents whose convictions have been supported by Meadow's expert evidence should be aggrieved. Yet it is clear that the current campaign against Meadow has won the backing of a range of activists who share a hostility towards science and expertise in general, and towards the medical profession in particular. There is a striking affinity between campaigners against Meadow and those opposed to immunisation and animal experimentation. Their tactics include vituperative personal attacks on prominent adversaries, extending to harassment, assault and referrals to disciplinary bodies.[7]

Although Meadow's views about child abuse are contentious, his work represents an attempt to reach a deeper understanding of the disturbing reality that every year a small number of parents, usually mothers, smother their babies. The denial of this reality by those campaigning against Meadow means turning a blind eye to infanticide. There is a danger that the onslaught on Meadow may result in the neglect of Emery's conclusion from a lifetime of investigating cot deaths — that 'we need to prevent these deaths, not victimise the parents' (or, we might add, the doctors).

Mike Fitzpatrick

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Disability Now

THE age structure of the population in the 20th century showed clearly that ageing of the population, with increased prevalence of disability, was inevitable. Advances in medicine have allowed many with congenital or acquired impairments to survive, sometimes, but not usually, without permanent disability. Doctors have tended to concentrate on cure and 'hospital training may perpetuate the belief that, if some degree of cure is not possible, then there is "nothing to be done".'[1] Factors such as communication difficulties and the appearance of people with disabilities lead to unease and avoidance by general practitioners.[2] Lack of knowledge about functional disability, social factors and anxiety is associated with less than optimal care, for example, for patients with osteoarthritis.[3] Opportunities to help may be missed and doctors rarely suggest an application for Disability Living Allowance or Attendance Allowance.[4]

In June 2003 the RCGP College Council approved the following policy statement on disability:

The Royal College of General Practitioners seeks to:

- Facilitate the training and the practice of present and future general practitioners through knowledge and skills and attitudes which will help and enable disabled people to live independent lives with dignity,
- encourage a wide spectrum of relevant research, and
- liaise with Government, professional organisations, independent organizations and other bodies, with a view to participating in the development of policy and services for the benefit of disabled people.[5]

In furtherance of this policy the College's Clinical Task Group for Disability is planning an Award to encourage excellence of care in general practice. Such care will enable people with physical disabilities. The Award will be given in recognition of an innovation or significant development in the organisation or delivery of care.

Applications may be accepted from any member of a United Kingdom based practice team including those undergoing vocational training or planning teaching for members of the primary health care team.

In addition a person or people with disabilities served by a practice may nominate that practice to receive the award.

Applicants will be able to describe how they have developed new services such as a specialist disability nurse, promoted contact with therapists, employers and voluntary organizations, given support to and learnt from disabled people, improved communication, patient information or teaching and training programmes.[6] Ideally innovations will be ones shown to be effective in practice. However, the examples given are not exclusive. In this developing field of care in practice many other ideas based on undergraduate or early medical experience, from general practitioner vocational training or as a busy general practitioner, trainer or course organiser may be very valuable.

There are changes underway in the education of health professionals,[7-9] but these will take time to disseminate. Meanwhile it is hoped that the Award will promote the recognition and sharing of current best practice in the care of people with disabilities.

Elizabeth H Muir
John McMullan
Charles Sears

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New columnists ...

Once again, many thanks to all who applied for the vacant slots of columnists at the *BJGP*. We publish three more entries on pages 236–237, and another three or so in our next issue.

Our regulars for 2004 will be **James Willis**, **Saul Miller**, **Dougal Jeffries** and **Emyr Gravell**.

Olivier Wong will send an occasional dispatch from Paris, and **Graeme Walker** from his changing training billets. **Mike Fitzpatrick**, **Neville Goodman** and **Richard Lehman** will appear monthly.

Enjoy!

Alec Logan

flora medica theophrastus bombastus

From the journals, January 2004

New Eng J Med **Vol 350**
11 Carriers of the genital herpes virus (HSV-2) are much less likely to pass it on to their sexual partner if they take valacyclovir continuously.
134 Why do some women with normal blood folate levels have babies with neural tube defects? Perhaps because they have autoantibodies to folate receptors.
259 A useful review of obsessive-compulsive disorder, to keep going back to. And back to. And back to. And back to again, just to make sure.
443 A newly-recognised major viral pathogen in children is metapneumovirus. Like influenza and respiratory syncytial virus, it can cause croup, bronchiolitis and pneumonia.
459 An old treatment for osteoporosis makes a come-back — strontium, taken orally as strontium ranelate over 3 years, increases bone density.
482 Testosterone replacement therapy probably does not increase vascular disease, but it can stimulate prostate cancer, so the authors of this review recommend transrectal biopsy before starting it. Volunteers please form an orderly queue...

Lancet **Vol 363**
139 Infective endocarditis has become so rare in general practice that it's easy to miss. Here's a comprehensive update.
150 Another disease to remember if your patient has an unexplained fever is malaria. Again, here's a comprehensive review, holding out the prospect of a vaccine in the medium term. Until then, new drugs derived from *Artemisia annua* are our best hope (pages 3, 9, 18).
185 The incidence of sudden unexplained infant death may be rising again in most European countries. The strongest risk still seems to be sleeping in the prone or side position.
197 A new way to assess the risk of osteoporotic fracture is quantitative ultrasound of the calcaneus. It proved highly predictive in the EPIC-Norfolk study. Cheaper than DEXA. Timely, given the warning about X-ray-induced cancer on page 345.
352 There has been a clamour for hospital stroke units in the last few years, but what about home rehabilitation programmes? They work very well, according to this systematic review.

JAMA **Vol 291**
47 Evidence-based medicine is supposed to be slow to reach the masses, but postmenopausal hormone use has declined by over 50% in the USA following the studies published in the last 2 years.
71 Yet the American masses still believe in cancer screening. Seventy-three per cent would prefer a whole-body CT scan to $1000 in cash.
186 The Framingham Risk Score can be augmented by various measurements to improve its predictive value — here it is a coronary artery calcium score. But the best predictor is much simpler: the waist/hip ratio (*Med J Aust* 2003; **179:** 580-585).
309 The best treatment for angina pectoris is a drug-eluting coronary stent (see *N Engl J Med* 2004; **350:** 221). But if your patient can't have one, there is a new and effective add-on drug for angina called ranolazine.
317 If you are already overspent from prescribing your Alzheimer's patients donepezil, add some memantine for extra cost — sorry, benefit.
442 Following breast augmentation, mammography screening can become less sensitive — in other words, boobs can occur.

Other Journals:
'Sex and the risk of restless legs syndrome': great title for a paper, but it's about the gender distribution of restless legs — see *Arch Intern Med* (**164:** 196). Elsewhere in this journal: exercise reduces weight in a dose-related manner, and 30 minutes of walking per day is a sufficient dose for most people (**164:** 31); morning headache is common and is much more likely to mean insomnia and depression than a brain tumour (**164:** 97); and some erectile dysfunction may have a genetic basis (twin study, **164:** 165). What kind of patient consent do you need? *Ann Intern Med* (**140:** 54) provides a useful discussion. Coffee consumption not only keeps the NHS going but also reduces the risk of type 2 diabetes (**140:** 1). If you have type 2 diabetes, homocysteine is a particularly strong risk factor (**140:** 94). Although obstructive sleep apnoea is common, important and treatable, we can't know how prevalent it is until there is a better case definition (*Thorax* **59:** 73). Childhood asthma and its treatment have no measurable effect on growth (*Arch Dis Childhood* **89:** 60); early antibiotic use does not increase childhood asthma (*Thorax* **59:** 11); and DNA vaccines may soon be available as a cure for allergic asthma — for birch pollen, see *Allergy* (**59:** 65). Are you turning into a werewolf? Seek help before you have to be hunted down by the London police with silver bullets: see *Acta Psychiatr Scand* **109:** 19 (Lycanthropy — psychopathological and psychodynamical aspects).

Plant of the Month: *Daphne blagayana*
A source of heavenly fragrance, like its sister *Daphne odora*, but smaller and sprawlier, with dark evergreen leaves and waxy white flowers.

Statistics — for fun and therapy

KACKER[1] laments general practitioners' lack of research opportunities. Certainly it seems ridiculous for a general practitioner to be financially the poorer when contributing to the public good by doing research. But single-minded attention to developing the practice has dangers, too, such as burn-out.[2,3] You are not better off if you give up your career because you get sick of it — spending time on research may be a good investment for its preventative or therapeutic pay-off, even by hard-headed criteria! One form that research can take, that is stimulating for the individual and productive for society, is the discussion of papers published in journals. And to this I would add, especially the statistical aspects. If a paper includes the raw data on individual patients, you can conduct what you consider an appropriate analysis. Does it agree with that of the authors? If not, write to the journal setting out your reasons for disagreement. 'Every investigator stands in need of expert criticism, for no pursuit runs between so many pitfalls and unseen traps as that of statistics'.[4]

I do not mean highly technical statistical or mathematical questions. But there are important scientific or medical issues that can get overlooked in the number-juggling, and which ought to be exposed for debate. Some of these recur repeatedly, and so I can make some specific suggestions. What is often most prominent is the result of a hypothesis test, so let's start with that and work back to the data.

The null hypothesis

Why have the authors chosen this H_0? A null hypothesis is precise, and may not exactly reflect the authors' (possibly vague) ideas and words. Suppose it is thought that an independent variable may induce a difference in one population but not in another. Should this be demonstrated by rejection of H_0 in one case and failure to reject H_0 in the other? If your answer is yes, do you appreciate that this could occur if the difference between the two differences is very small? It might be more appropriate to test for a difference of differences (i.e., an interaction).[5] Another vexed issue occurs when three groups are being compared. The data may be compatible with the idea that group 3 is different from groups 1 and 2 (averaged), which themselves are similar (that is, H_0: $\mu_1 = \mu_2$ is not rejected, and H_0: $\mu_1+\mu_2 = 2\mu_3$ is rejected). But the data may also be compatible with the idea that the groups are different, group 2 being halfway between groups 1 and 3 (that is, H_0: $\mu_1 = \mu_2= \mu_3$ is rejected, and H_0: $\mu_1 + \mu_3 = 2\mu_2$ is not rejected). If it is plausible that group 2 is intermediate in respect of some independent variable (e.g., the groups may be labelled none, partial, full), then the first idea suggests some sort of threshold before the effect of the independent variable is felt, whereas the second idea suggests a more gradual (linear) impact. It is easy for an author, attached to a pet theory and finding results compatible with it, to forget that the data may simultaneously be compatible with a different theory.

The alternative hypothesis

The test employed will have greatest power against some particular H_A. Why have the authors chosen this H_A? It is common to test for differences between means, under the assumption of equality of variabilities. But differences of variabilities may be equally interesting and plausible as differences of means. In that case, one should employ a test that is sensitive to both types of differences.[6]

Why have the authors chosen this summary statistic?

A simple example is the issue of choosing between the mean and the median. Easier to overlook are choices between slightly more complicated statistics. For example, everyone is familiar with correlation. But they may not appreciate that it reflects a ratio, the denominator being the variance in the population, and therefore a given accuracy of prediction results in a lower correlation if the variability in the population is low than if it is high. If size of error is what you are chiefly interested in, that's what you should calculate, not correlation.[7,8] One popular statistic that is frequently misused is kappa: in the context of observer agreement regarding ordered grades, there are separate issues of bias and correlation, and therefore at least two statistics are needed, not one.[8,9]

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Why have the authors chosen these numbers as their data?
Most researchers are in the habit of taking their measurements at face value, and subtracting or averaging them accordingly. But if the numbers do not properly reflect the quantity of interest, they should be modified. For example, there might be a healthy range, within which variation is uninteresting, and a progressively more unhealthy range. If variation within the range extending up to 100 (say) is uninteresting, and severity of pathology is measured by how much this score of 100 is exceeded, then if severity rather than raw score is what is of interest, we should recode all scores of 100 or less to 0, and recode all scores of over 100 by subtracting 100 from them.[10] Sometimes we may even wish to question whether the numbers are really numbers. If they are not numbers, they cannot be subtracted or averaged. Does a change on the Beck Depression Inventory from 30 to 25 equate to a change from 15 to 10? If, but only if, these are numbers, then it does. Or suppose three patients have 5%, 50%, and 95% stenosis, and another three patients have 50%, 50%, and 50% stenosis. If we average, these two groups are equivalent; averaging is valid if, but only if, these are numbers.[8]

The numbers, the summaries of numbers, and the hypotheses about the summaries of numbers are at the foundation of much research. If they are in question, necessarily the conclusions are also, yet too rarely do researchers get challenged. But, although it is exciting when you discover something new in a dataset, a word of caution about hypothesis tests is needed. You should not overstate the meaning of any test that you perform: *P*-values only carry their full meaning if the tests are specified before seeing the pattern of the data. So either you need to argue convincingly that there is good reason to follow your line of analysis, or else you must make clear that it is largely descriptive rather than inferential.

T P Hutchinson

... springtime in paris olivier wong

Evaluating the healthcare system in France

For years France was the Mecca of clinical training at the sickbed: students came from all over the world to 'imbibe' the gospel of clinical practice and listen to the masters: what they said was thought to be of universal authority and validity. It is a caricature which has been much exploited by medical literature and the cinema. And even if it looks hidebound today, that kind of training had an undeniable advantage: future doctors had to know the semiology of illnesses by heart, sharpening their critical instincts and solid common sense by trying to resolve actual clinical cases under the vigilant gaze of the master. This master–apprentice system culminated in the 'externat', a 3-year long period of hands-on experience validated by a difficult competitive examination that had to be taken by all students, including future general practitioners. The events of May 1968 overturned many traditional aspects of French life. They did away with the 'externat' and swelled the number of students trained every year almost four-fold. In the 1970s the master– apprentice system collapsed under the pressure: it was no longer possible to have an individualised system of clinical training in view of the huge numbers of students in relation to teachers. This plethora of wannabe doctors subsequently led to the application of a *numerus clausus* system in the 1990s, with a dramatic curtailment in the number of students admitted to each faculty. France therefore has a very oddly and unequally distributed age pyramid: almost half of the 201 400 doctors in the country are aged over 50 years old. These facts, and the loss of prestige and power of professors and heads of department in the big university hospitals, have allowed hospital directors to emerge as the dominant decision-makers in the hospital world and have contributed to the emergence of a new 'evaluation culture' with the promotion of standards and guidelines for practice, along with the setting up of a national quality assurance programme for both doctors in private practice and clinical staff in hospitals.

Two state agencies created at the beginning of the 1990s play a key role in medical evaluation in France. The task of ANAES (National Agency for Health Accreditation and Evaluation [http://www.anaes.fr]) is to coordinate efforts to elaborate principles and recommendations for good practice, hospital accreditation and evaluation of private practice. Paradoxically enough, current French law is quite severe as far as hospitals are concerned, subjecting them (like any business) to a lengthy and tedious accreditation process in terms of internal organisation, although individual medical practice is not subject to any kind of evaluation and no analysis is made of the clinical and prescribing habits of hospital doctors in comparison with current standards of good practice. Vice versa, general practitioners or specialists practising in private practice have been encouraged, on a voluntary basis, to have their clinical activity audited by peers specifically selected and trained by the ANAES every 5 years. The individual and collective organisation of medical surgeries does not fall within the remit of this legislation, a major shortcoming since it is blindingly obvious that the real problem, in view of the tendency of health professionals across the country to work solo or at best with one partner, is the total lack of standards in terms of ensuring continuity of healthcare, reception, premises, archiving of medical files, transmission of data, and organisation of skills and responsibilities. Nobody can say with any confidence who does what in French private medical practice since everybody is doing his or her own thing (choice of patients, type of care, hours)!

The purview of the AFSSAPS (French Health Product Safety Agency [http://www.agmed.sante.gouv.fr/]) is to ensure that drugs are properly licensed and registered in the formulary, to issue recommendations for good pharmaceutical practice and to supervise the practical use of drugs and medical devices. Both agencies are required to coordinate their activities in order to avoid disputes about jurisdiction, especially with regard to drawing up recommendations and information provided to professionals.

But it has to be said that there is little rigorous evaluation and measurement of the impact of measures taken to promote quality in French medicine. Most studies done are simple before–after evaluations without prospective value, and it is accordingly difficult to determine whether a promotion campaign exerts any positive effect at all. Nevertheless, the notion of evaluation is high on the agenda in the French medical world, and critical practice and evidence-based medicine are not entirely foreign concepts on this side of the English Channel. The historical irony, of course, is that the French are now having to import ideas their ancestors once gifted to modernity ...

http://www.agmed.sante.gouv.fr/
http://www.anaes.fr

Evidence-based medicine: a matter of belief

It is the spirit of the age to believe
that any fact, no matter how suspect,
is superior to any imaginative exercise,
no matter how true.
(Gore Vidal)

Columnists and opinion writers don't really expect to change the world, but they expect to be engaged, even reviled. It's like teenage crushes: it's best to be loved, but almost as good to be hated because there is little between love and hate. What hurts is indifference, being ignored. It drains the enthusiasm.

The critics of evidence-based medicine (EBM) have been studiously ignored. To avoid the riposte about preferring medicine not based on evidence, I need here to restate a simplified definition of EBM, which is that it is largely based on randomised controlled trials (RCTs) assimilated by meta-analysis, or on megatrials. I am not going to rehearse the criticisms here, although it would do no harm because they remain largely unanswered. But I want to recount what happened when I attempted to engage in dialogue with the orthodoxy that EBM has become. Remember that EBM was put forward as an objective way of judging best treatments, which would enable medical practice to move beyond the arbitrary authoritarianism of experts. EBM claimed to replace authoritarianism by due authority: medical practice based on the proper assessment of evidence — and who could argue with that?

Well, quite a lot of people, foremost among whom was Alvan Feinstein, who died in 2001. Many of the essays critical of EBM, including my own, were in truth restatements of Feinstein's ideas, and he has been much cited. Feinstein was highly critical of EBM's reliance on RCTs. He acknowledged that RCTs have been: 'spectacularly successful in solving many of the particular problems at which they were addressed', but worried that they too often ignored factors important in making clinical decisions.[1] He also warned that: 'evaluation of quality in RCTs is not an easy task', and questioned the source of authority in EBM, which more or less assumed that the data spoke for themselves.[2] I'm sure the proponents of EBM would agree about evaluation of quality, but they have more faith in their scoring systems than Feinstein would have allowed them.

Feinstein wrote or co-wrote many papers, but curiously he is not cited by the proponents of EBM. I say curiously because this seems to contravene the central tenet of EBM that all the evidence be searched out and considered. This extends in some proponents' view even to searching out all the grey literature — the conference proceedings and society abstracts that most clinicians are deeply suspicious of and would be most wary of generalising to their patients. Yet when it comes to whether EBM itself is soundly based, there is no similar insistence on searching out. Enthusiasts are happy enough to cite one another's favourable opinions, but not to seek to refute those of the critics.

Although not restricted to EBM, a serious difficulty when considering treatment for an individual patient, as alluded to above, is knowing whether it is best for that patient. The chief executive of a large drug company said as much in his recent statement that: 'most treatments don't work in most patients'.[3] While the media affected much huffing and puffing at this, how else to interpret numbers-needed-to-treat? If most treatments worked for most patients, the statistic would not be needed. The application of epidemiological methods to individual treatments is central to Feinstein's argument: the distraction of quantitative methods, as he put it.[1] By restating and developing this argument, many critics have challenged EBM with the practical problem of how best to treat the individual patient.

And then, a year or so ago, an article appeared in which some eminent proponents of EBM wrote that, to paraphrase, it was becoming apparent that not all patients were the same and that it could be difficult applying the findings from EBM to an individual. This was presented as if it were something new: one could hardly find a better example of medical chutzpah.

I had never met any of the authors. Using the article as a prompt, I e-mailed a short message to one of them to ask two questions. I gave the reference to an article that I had written, and asked whether he had read it and how he would answer it, but I asked also if he was aware of any refutation of Feinstein's much quoted work. In his first reply, anodyne and no longer than my message, he answered neither question, making no comment at all about my article. I e-mailed again. This time, in a shorter message than my first, I asked just about Feinstein, and whether there had been, to the author's knowledge, any formal refutation of Feinstein's criticisms of EBM.

One of the features of science, as opposed to politics, is that one tries to persuade by facts and reasoning. True, that is the ideal: there is much empty rhetoric in what passes for science; and there are honest politicians. Nonetheless, in science there are dialogues. Ideas are argued for and against. The reply I received was so unbelievable that I simply ceased to care. The episode, as good a stimulus for the columnist's normal response of an angry thousand words as one might wish for, was demoted to being an aside in a chapter of a specialist book. But thinking

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more about it, it is more important than that. Whether or not EBM will eventually be a force for good in medicine, we need to know what impulses and thought processes can lie at its heart.

I received no formal refutation, nor a reference to a refutation that I could search out. Feinstein, he wrote, believed in absolute truth, whereas EBM relied on probabilities. I must admit that I do not quite follow what this means but, whatever its meaning, it is only a description of the difference between the two positions, not a refutation. I could not e-mail back to ask for clarification because the second paragraph of his two-paragraph e-mail informed me that if I was in Feinstein's camp, then philosophically we were poles apart and he was not going to correspond any further.

Which he didn't. I replied with a pleasantry or two, and commented that there were probably more important ills in the world than our disagreement, but the olive branch was ignored. To him, most likely, I was a flat-earther, and therefore not worth speaking to.

But in all honesty what else did I expect? Chomsky wrote that it is pointless speaking truth to power, and EBM is power. EBM is, however humble its proponents appear, the new authoritarianism in medicine that brooks no argument, but: 'the pronouncements … come from Cochranian Oxford rather than Galenic Rome'.[2]

This is not good for medicine. There are particular treatments that are proven beyond doubt, but there is no axiom that states EBM will identify these best treatments, nor that all treatments need EBM to prove their worth. EBM is not *the* approach — it is *an* approach — to trying to decide what is best for a patient. It is an approach which, because it is based on epidemiology, is flawed. That does not mean that all meta-analyses are invalid, but that they do not have an automatic seal of approval just because they are EBM. If Feinstein had a different philosophy, why should we simply have to believe that the philosophy of EBM is the right one?

Neville Goodman

Commentary

I suppose that as an enthusiast for evidence-based medicine (EBM) I would be expected to disagree with most of the points Goodman makes. To a certain extent I do, but that is because he defines EBM as 'largely based on randomised controlled trials (RCTs) assimilated by meta-analysis, or on megatrials' and, pointing out that you cannot base medical decisions on RCTs alone, castigates EBM as though that was its aim, and its proponents as though they were 'intractably deaf and increasingly arrogant'.[1]

Each of these propositions is, at best, a half truth that represents an extreme reductionist view of EBM. There are of course, as Goodman hints, powerful vested interests (big pharma and expert groups) that promote a reductionist interpretation of analytic research (mostly RCTs). They then impose their version of it as preferred (indeed almost obligatory) clinical practice under the (dis)guise of EBM. They are able to do this because the techniques of EBM confer power,[2] and most clinicians do not aspire to master them.[3] If this is what Goodman is criticising, then I am with him all the way.

Where I part company with him is in his assertion that he does not know what it means to say that EBM relies on probabilities rather than absolute truth. I am always surprised at EBM workshops to find how little most clinicians understand of basic statistics, probabilities or research methodology. They feel unable to challenge those who do understand them. The aim of EBM teaching is to encourage an understanding of the limitations and benefits of published research and, through clinical epidemiology, how to relate research findings to clinical choices. This is accompanied by some healthy scepticism, a smattering of epistemology, a taste of role play on occasions, and an insistence that each participant is fully capable of acquiring the knowledge and skills of EBM.

If nothing else, most do begin to understand that RCTs are not explanatory, but probabilistic,[4] and that their application in clinical practice must take account of the patient's needs and expectations. When GPs acquire high level EBM skills they turn out to be both more confident in explaining the probabilistic outcomes of treatments and more willing to allow patients a full share in making clinical decisions.[5]

I am not surprised that Goodman's unnamed EBM correspondent became uncommunicative. One of the tenets of EBM is that it is impossible to read everything, and that what you read should be relevant to your clinical practice. I too have never read Feinstein, but if he has been widely cited, no doubt I have read some of his arguments. However, I doubt that reading him would change my world view and I have to make a judgement about whether I should spend time searching him out and reading him. But it should be my judgement, not someone else's. It would be interesting to perform a systematic review of articles critical of EBM, although I think this would have mainly sociological relevance, since most of them criticise their authors' socially constructed views of EBM rather than the reality.

Goodman's analysis of the tyranny of evidence is partly correct, but he is aiming at the wrong target. Goodman, in his reaction to EBM, resembles some over-sensitive consumer activist whose introduction to beer drinking and beer drinkers consisted of a rowdy Saturday night on Newcastle Quayside. He has never forgotten the disgusting, urine coloured, gassy fluid that he was forced to drink, nor the garish, loud drinkers speaking an incomprehensible dialect who seemed so threatening following a poor showing by Newcastle United. Therefore he writes diatribes against mildly eccentric people who are usually to be found in quiet Oxford pubs appraising the merits of this or that real ale and arguing over the correct balance of barley, malt and hops. Perhaps we need to have a campaign for 'real EBM'.

Toby Lipman

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Obesity — the challenge ahead

OBESITY is now the major nutritional disorder facing the developed and even the developing world.

Back in 1976 a joint Department of Health/Medical Research Council group concluded that: 'Obesity is a hazard to health and a detriment to wellbeing, common enough to constitute one of the most important medical and public health problems of our time'.[1]

At that time obesity affected less than 6% of men and 8% of women; in 2001 21% of men and 23.5% of women were afflicted by obesity and its comorbidities.[2]

Currently overweight and obesity may account for as much as 30% of coronary heart disease and 70% of new cases of type 2 diabetes,[3] but the reality is that virtually no system of the body is spared its ill effects.

It contributes to the development of osteoarthritis, dyspnoea, sleep apnoea and venous thromboembolism; site specific cancers; makes pregnancy and surgery more hazardous and contributes to psychological distress and low self-esteem.

Yet historically in the United Kingdom obesity has been trivialised in the media and marginalised by the health service and, until recently, has not received the degree of scientific attention that its importance deserves.

The World Health Organisation, despite its historical focus on malnutrition and starvation, has now recognised the problem of overnutrition and in 1998 said: 'The epidemic projections for the decade are so serious that public health action is urgently required.'[4]

Unfortunately many members of the public and, indeed many health professionals often view obesity simply as a problem of eating too much and exercising too little when in fact it is a complex, multifactorial disorder of appetite regulation and energy metabolism that involves genetics, physiology, biochemistry, and neuroscience ,as well as environmental, psychological and cultural factors.[5]

Obesity is of course not increasing because people are consciously trying to gain weight. In fact millions of people in the country are dieting at any one time; they and many others are struggling to manage their weight, to improve their appearance, feel better and become healthier.

Those with a genetic predisposition to store energy as fat, which in evolutionary terms was a useful attribute, have this genetic tendency fuelled by the current obesogenic environment in which physical activity has virtually been abandoned and in which there is a plethora of energy dense foods.

The total direct costs of treating obesity were estimated to be £479.4 million in 1998 and the indirect costs, defined in terms of lost output due to sickness or premature death, were in the region of £2.1 billion.[2]

These figures will rise inexorably unless the present epidemic is reversed. Such mounting costs could seriously prejudice the basic philosophy of a health service which is based on need and not on the ability to pay; a service free at the point of need.

Of particular concern has to be the increasing prevalence of childhood obesity. Analysis of the Health Surveys for England suggests that 8.5% of 6 year olds and 15% of 15 year olds were estimated to be obese.[2]

Furthermore it has been shown that features of the 'metabolic syndrome', increased blood pressure, atherogenic lipid profiles, hyperinsulinaemia, central adiposity and increased changes in left ventricular mass are present in obese children. (P Betts, Annual Symposium of the Society for the Study of Human Biology The Biosocial Society: Childhood Obesity, Loughborough 15-17 Dec 2003) These must pose significant risks for the health of a future adult population, increasing the likelihood of death from type 2 diabetes, cardiovascular disease and certain cancers. (P Betts, Annual Symposium of the Society for the Study of Human Biology The Biosocial Society: Childhood Obesity).

In fact being overweight and obese in adolescence doubles the mortality rate for men aged 50 years and increases the cancer risk by as much as 14% in men and 20% in women. (P Betts, Annual Symposium of the Society for the Study of Human Biology The Biosocial Society: Childhood Obesity).

We are in danger of producing a generation whose life expectancy could be less than that of their parents.

Yet we live in an era which sanctions the intensive advertising of energy dense fast foods, targeted at children; an era in which physical activity and how to achieve healthy nutrition hardly figures in the curriculum of many schools; an era in which school playing fields are being sold to balance budgets; an era in which many children are liberated during the school lunch break to fall prey to the purveyors of energy dense food and drinks, and an era in which the makers of foods of drinks that foster obesity have tacitly been given access to classrooms. Does this all make sense?

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But the health risks are not confined to physical disorders. Psychosocial problems are in fact the most common and immediate form of morbidity associated with childhood obesity. (AJ Hill, Annual Symposium of the Society for the Study of Human Biology The Biosocial Society: Childhood Obesity, Loughborough, 15-17 Dec 2003).

While the bad news is that the prevalence of obesity is rising, the good news that has emerged over the last few years is that relatively modest weight loss can have a marked effect on the risk profile associated with obesity. Until quite recently the obese were urged to strive for the achievement of ideal body weight, which required such massive changes in the eating patterns and lifestyle of individuals that for the majority of people it was doomed to failure.

One of the most important findings from relatively recent research into obesity is the benefit to individuals of a 5–10% weight loss in improving their risk profile.[6]

The fact that it is no longer necessary to strive for the well nigh unachievable ideal body weight should motivate health professionals to take a much more positive attitude to treating obesity. Perhaps the first step is to recognise obesity as a chronic disease in its own right and afford it the time and effort given to managing other serious chronic diseases such as hypertension. In other words not just diagnosis, but support and follow-up together with the appropriate use of drugs and surgery.

Obesity is such a serious health problem that it deserves a structured approach to its management as hypertension and diabetes.

The goals of obesity treatment need to be refocused from weight loss alone to include weight management as well, and success judged more on the impact on the overall health of individuals rather than the achievement of ideal body weight.

If people could be persuaded and helped to avoid becoming obese it would bring enormous benefits to individuals in terms of improved longevity and quality of life, as well as bringing significant savings on health expenditure and benefits to society as a whole.

Tackling obesity will require two complementary approaches. The first is a population-based preventive approach that aims to reduce the prevalence of obesity across whole communities; the second is a treatment service targeted at those with obesity and comorbidities or obesity and a strong family history of either type 2 diabetes or coronary heart disease.

The population-based approach has to be led by government and must include managing the food chain. It will require a collaborative approach between government, local authorities, the food and leisure industries with the goal of achieving a much less obesogenic environment. It will require cross-government working and should be led by an individual with cabinet ranking — it is that important!

The second, personal or high-risk approach, will require the development of locality-based treatment centres, because the current workloads shouldered by the primary care teams will prevent them giving the time for the effective management of this most pervasive health problem.

The job of primary care teams will be to identify those obese at-risk individuals and refer them to their local treatment centre.

Such an approach would allow a co-ordinated approach to obesity management across a health district, abolish postcode management, ensure the appropriate use of drugs, the selection of people for surgery and be capable of vigorous audit.

The ramifications of obesity are immense. It is intimately and causally related to the development of some of the major diseases affecting the westernised world and beginning to appear in the developing world. These cause much human suffering and premature loss of life, as well as placing massive burdens on society.

Obesity is not a simple matter of gluttony or sloth,[7] but a major disorder afflicting those with a genetic predisposition and which is fuelled by today's environment. As such, it merits consideration as a disease in its own right and appropriate steps need to be taken to prevent its occurrence and manage its consequences.

Colin Waine

So Shall We Reap (How everyone who is liable to be born in the next thousand years coul and why, in practice, our immediate descendants are likely to be in serious trouble)
Colin Tudge
Allen Lane, 2003. HB, 437 pp, £20.00, 0 713 99640 4
Fast Food Nation: What the all-American meal is doing to the world
Eric Schlosser
Penguin Books, 2002. PB, 386 pp, £7.99, 0 141 00687 0
The Jungle
Upton Sinclair
Penguin Books, 1985. PB, 412 pp, £6.99, 0 14 039031 6

SHORTLY after I first started work as a doctor, I came across *The Famine Business*, by Colin Tudge, a book which changed my approach to food and eating, and has influenced our family diet ever since. The purpose of the book was to identify the policies — agricultural and gastronomic — that would enable us collectively to feed the entire world's human population adequately. The key was to identify the world's farming land as the finite resource, and work out how to use it most productively. Use the land less for meat, but not cut it out altogether (lamb on Welsh hill farms was one example where the land cannot realistically be used for anything else), eat less meat and more vegetables especially grain and pulses.

More than 25 years on, Colin Tudge has returned to the theme with 'So shall we reap …'. The intervening years have been spent accumulating more detail to support the general thesis. New problems have emerged. We now have to consider climate change, more food-born infections, and global shortages of fresh water, as well as humanity's propensity in the rich part of the world to over-eat. However, in one particular there is a hopeful note. Far from increasing exponentially to destruction, the world's human population will stabilise around the middle of this century at 10 billion. According to the archaeological evidence, humans have farmed and lived in farming communities for the last 10 000 years. If we can get the policies right for sustainable farming to support the expected 10 billion, we and our descendants should be able to lead secure and healthy lives for the next 10 000 years.

We can achieve this first by approaching the problem from a biological perspective, understanding the biology not only of ourselves and our nutritional needs, but also the biology of the animals and plants we eat, and of the finite land. We should also, and this should appeal to general practitioners, treat farming as a craft and not a technology, respecting the thousands of years of experience that have informed farming practices. Not that this is an anti-technology tract. Micro-irrigation will help to eke out precious water resources. While Tudge does not think genetic modification (GM) is going to solve the major problems of nutrition on its own, he gives examples of GM plants that we might in the future find a real godsend: more drought resistant sorghum for populations living on the edge of deserts, or the beautifully fanciful notion of frost-resistant strawberries growing like Virginia creepers up the sides of buildings in northern cities. In the long run, human survival is going to depend on traditional, mixed farming, with the emphasis on producing sufficient quantities of the three main staple foods: wheat, rice and maize. In among the staple crops, we need animals to increase the land's productivity — he quotes the evidence that arable farming is more productive when animals are mixed in — and intensive horticulture to increase variety in the diet and nitrogen in the soil. The need to eat less meat abides. Because of the inefficient way in which they use land, farming beef herds means, in effect, that we would need enough land to feed not 10, but 14 billion humans. One of the virtues of changing agriculture will be that more people will be employed on the land, reversing the trend of the last 200 years. That way we create more jobs and revitalise rural communities. The ideal is termed enlightened agriculture: '… common-sense agriculture: rooted in good husbandry; traditional in structure, yet making all the use it chooses to of the very best science and (where appropriate) the highest technology; guided by biological reality (ecology, physiology) and by the human values of kindness, autonomy and justice.'

Colin Tudge presents a powerful argument. Because of everything that's changed, as well as all the extra detail, it's even more persuasive than 25 years ago. But another change in that time is the triumph of capitalist market solutions to all economic questions, and an economist would ask why agriculture, alone of all economic sectors should be allowed to operate outside normal market forces. For one answer turn to *Fast Food Nation*, a truly terrifying account of raw capitalism applied to the same set of questions. We all know that the fast food industry produces food of blandly uniform taste, with nutritional values seemingly designed to ensure the healthy survival only of the coronary artery bypass industry. Eric Schlosser, however, painstakingly records the other consequences. Intensive rearing and slaughtering of beef cattle in large numbers creates unparalleled opportunity for infections to spread among the animals, including of course, BSE. As business has become bigger it has exerted more power over every aspect of production and supply. The land is increasingly owned by corporations, and a whole mythic way of life disappears with the demise of family ranches. There are the depressing working conditions of those who staff the outlets. Worst of all are the stories of poor immigrants working in the slaughterhouses, risking and often suffering horrific industrial injuries. Given the nature of the task, this is an industry that will always be difficult to mechanise. Indeed the conditions and injuries haven't changed much since the

d eat very well indeed;

earlier fictionalised account, focused around the Chicago stockyards, by Upton Sinclair in *The Jungle*, published in 1906. Then wages were kept low by importing labour from Northern Europe; now the production is in the South and the labour comes from Central America. Schlosser's account lacks the visceral horrors of Sinclair's, but then Sinclair's target was primarily labour conditions and not the meat industry. When the US government's response was not improvement of working conditions but the appointment of numerous food inspectors to oversee meat production, Sinclair wrote that: 'I aimed for the public's heart and by accident I hit it in the stomach.' Eric Schlosser invites us to share his horror at every aspect of the fast food industry and hopes it will come to be seen as a temporary aberration born of the 20th century's narrow views of profit and loss, and blind application of science. His optimistic conclusion echoes that of Colin Tudge: 'Whatever replaces the fast food industry should be regional, diverse, authentic, unpredictable, sustainable, profitable — and humble. It should know its limits. People can be fed without being fattened or deceived.'

How we, as consumers and doctors, encourage moves back to the agriculture and gastronomy that we desire is not easy, and neither of these books provides a satisfactory answer. Perhaps that is asking too much. Colin Tudge devotes a chapter to it, but it is the only one in his book where his conviction and command of the debate falters. As everywhere else the power of the big corporations — fast food suppliers in the US, and big supermarket chains in the UK — seems to consumers unchallengeable. Yet doctors in the recent past associated themselves with three campaigns with degrees of success: for the wearing of seatbelts in cars, against nuclear weapons, and against smoking. Where diet is concerned the steps are less obvious than the passing of regulatory laws, but it's territory that we already discuss with patients and that is as much in the medical domain as smoking. General practitioners could even claim to be the group best placed to expound biology to the public at large. As with all areas of our patients' lives we have to be careful before we start interfering with habits deep rooted in their cultural and social lives. But the current problems with the national diet are obvious to all, and cannot be ignored. The prize goes beyond the health of today's population. It is the survival of the human race for the next 10 000 years.

David Jewell

General practice at sea

I have taken time out of mainstream general practice in order to sail to New Zealand with my husband. It is relatively easy to leave the job, but it is an internationally recognised vocation you take with you. Interesting scenarios among the yachting community.

There is a camaraderie among this community based on individuals taking responsibility for their actions enough to spend 2 and 4 week spells out of sight of land, and the facilities there. There is a 'law of the sea' that if a boat is in distress at sea, then you should offer to assist if possible. This ethos extends to an unwritten neighbourhood watch in anchorages and much more. There are not many places left where you meet a new neighbour and within 10 minutes of chatting have invited them to your home that evening.

Picture this scenario: You are in an anchorage in the Cape Verde Islands (all the yachts there have sailed from the Canaries, and will be crossing the Atlantic over the next few weeks.) You meet a woman for 2 minutes that morning while dropping off a book for her husband to borrow. In conversation, she is unwell with 'the runs', which have lasted over a day now. She's putting on a brave face, and she's miserable, but she's not critically ill.

Your deferred defence union membership leaves you covered only for Good Samaritan acts, i.e. bona fide medical emergencies. You have also been advised by peers back home to avoid all patient contact in order to avoid possible litigation. With this in mind, you give only neighbourly sympathy and leave her to take responsibility for her own diarrhoea.

Later that day your partner is helping with repairs on another boat, and in conversation your profession is mentioned. Oh how lucky — would you mind calling on a lady with really bad diarrhoea who is worse than she is letting on? Several people are concerned about her.

What would you do?

This is not likely to be a medical emergency, but you don't know how much worse she may have become unless you see her. Realistically, you are unlikely to have indemnity cover. Is it sufficient though, to only consider whether or not your back is covered? There is the potential to do good here in terms of her comfort and safety. Clearly if it comes to the need for IVT, then she will need to be encouraged into hospital.

Ethically we are supposed to 'do no harm'. You are unsure of the quality of the local medical services ashore, which would be the alternative if you decline to see her. If you do NOT visit her, given that there are several people concerned about her, could you sleep soundly, knowing that you chose the non-litigious option?

What about getting her to sign a disclaimer before you see her? In theory a wise idea, but in practice does it have a legal value, and is it worth the implied distrust? There is an innocent community at stake here among long-distance cruisers (for the meantime at least). People offer unconditional assistance in their trades, and receive payment in kind all based on trust. In this lifestyle there are few guarantees. If you want to wait to find a professional ashore to do the job, then fine.

If there are none available and you do not want to accept the consequences of a Good Samaritan act, you have the option to decline the help. It is difficult to imagine who would complain to the tradesperson that their sail or engine repair failed in critical circumstances. Finally in this case, you must consider whether the patient actually wants help? She did not ask for it personally, but then she did not know there was a doctor around.

I went to see her. I judged this was a low-risk case with a good potential to help. She was grateful for the visit and it felt wrong to ask for an indemnity signature in this case. She gave a history of severe but simple diarrhoea. She was mildly clinically dehydrated so we discussed alternatives to the plain water she had been drinking and I gave her some Dioralyte®. We discussed the use of antibiotics, and of course NOT setting off across the Atlantic until fully rehydrated. I continued to review her and she did settle over the next few days, with the help of her own supply of antibiotics.

I am glad I made these decisions about when to use my skills and would consider making the same ones again. Is this naive and foolhardy or is it what the vocation is about?

Katy Roff

On poetry

I went to see my GP the other day. During the few minutes I waited to see him (he runs to time much better than I do) I picked up a leaflet of *Poems for the Waiting Room*. A simply produced but well designed anthology of short poems by different authors. The project, initially sponsored by the King's Fund but since taken up by NHS Estates, provides leaflets of poems for several hundred general practice and hospital waiting areas.

This reminded me how little attention is usually given to our waiting rooms, where many patients spend as much time as they do with the doctor or nurse they have come to see. Apart from the replacement of the old wooden benches with reasonably comfortable chairs, waiting rooms in most practices I visit differ little from those I sat in as a child. Entertainment is still out-of-date magazines, fading health education posters and in the more adventurous ones perhaps a few pot-plants or a tank of tropical fish. The more modern the practice the more the waiting room seems to resemble that nadir of waiting experiences, the airport 'lounge'.

Poetry can be a life-enhancing way to pass time in unattractive places. *Poems on the Underground* has proved this for years. Their short verses on tube trains are certainly an improvement on adverts for travel insurance or cheap phone calls when the carriage is too crowded to read a book or paper. Other countries have copied the idea on their underground railways.

But what about poetry in the consulting room? My heart certainly leapt up as I read some of the poems, and this made me wonder about the therapeutic role of poetry in mental health. There is evidence of interest in this outside the medical world. One can buy collections of poems to help you get through the day, understand men (or women) or help you to stay sane. I recently heard a rather aggrieved contemporary poet on the radio complaining that bookshops stock these, but not slim books of verse from contemporary poets. I was reminded of the complaints of drug companies undercut by cheap generics.

Attempts to dissuade people from medicalising their problems have not been spectacularly successful, if my consultation lists are anything to go by. People continue to bring their frustrations at work to the doctor as stress, their ontological insecurity as depression, unhappy marriages as heartburn and elderly relatives as pains in the neck. If we cannot demedicalise problems then perhaps demedicalising therapy might be a more practical alternative. We now prescribe exercise — why not poetry — or other art forms? Vivaldi not Valium®. Cézanne instead of citalopram.

Is poetry an effective therapeutic tool? Alas, neither MEDLINE nor Cochrane revealed any randomised controlled trials on the effects of reading poetry, though rather worryingly there are case reports of poets (Sylvia Plath and Emily Dickinson) whose mental health does not seem to have been helped by writing it. A thorough evaluation report of the *Poetry for the Waiting Room* project provided qualitative evidence that both patients and staff approved of the project, but did not specifically consider its clinical impact or therapeutic indications.[1]

In these days of evidence-based practice more research is needed. The randomised controlled trials will have to be single blind of course, comparing sonnets with 14 line articles from *Homes and Gardens* (unless someone can produce a placebo poem which looks precisely the same as a real poem, but lacks the active ingredient of poetry. Traditionalists may feel that some modern poets have inadvertently achieved precisely this effect, but the laws of libel prevent me from suggesting possible names).

Encouragingly a writer of 'fairytales' has recently joined the RCGP research team.[2] Perhaps the time is ripe to plan a research bid for a multicentre trial of the impact of Shakespeare on stress?

Peter Toon

Home visit

TWENTY years ago as a medical student living in hard-to-let council flats I first experienced the pungent ammoniacal whiff of the lifts and now, like urban foxes marking their territory, the children and grandchildren of my erstwhile neighbours are peeing in exactly the same places. And, like their parents and grandparents, the lifts are not working or 'out of order'. This, of course, being subtly different from 'totally out of order', in that this accusation would be swiftly followed by an exchange of punches. Try this with a lift and you are likely to come off second best.

Government league tables are a poor indicator of educational attainment in Tower Hamlets. The discovery of new ways to vandalise the entry phone systems is a far better measure. Will the digital display have been obliterated by an aerosol of silver paint or will the press button have been jemmied with a power hammer? Will the video camera view me through a darkly cracked lens?

Will I sound like the 'Terminator' when I press my breath into the receiver of the ansaphone?

'It's the doctor'
'Who?'
'It's the doctor'
'What?'
(shouting now) 'IT'S THE DOCTOR!'
(sounds of another voice) 'You can come up. It's number 93.'

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Woolf
1.Neighbour R. *The Inner Consultation: How to develop an effective and intuitive consultation style.* Newbury: Petroc Press, 1987.

Would it have been easier if I had stood in the street and bellowed at the top of my voice? Yes. Now every mugger within a 200-yard radius knows exactly who and where I am.

I pass a disgruntled concierge who could have let me in all along if he had been either interested or half awake.

'Ooo are you?'
'The doctor'
'The Ooo?'
'The doctor'
'For Ooo?'
'Number 93'
'Kindly, please wait.'

He presses digits on a phone.

'He says it's the doctor ... the doctor … THE DOCTOR.' A long pause and then back to me. 'Number 63 says they're not expecting no doctor.'

'That's because I'm visiting number 93.'

'Kindly, please sign your name.'

He lets me through after I have written 'the doctor' just below T Blair and G Bush on the register.

'—— social workers', he mutters under his breath as I sweep past.

So it's up the stairwell scattered with the ubiquitous syringes and orange needles, cold concrete even in August heat waves, hard on your shins when you slip on the grease, past swing doors on each floor all with their bottom toughened glass panels kicked out. Large drops of dark red blood — a sign of the easy, casual and accepted violence that is part of life on this estate or perhaps just a heavy nose bleed with a lack of Kleenex? Everywhere the same sweet, fatty smell from the rubbish chutes — a sickly 'lively' nose with a gag-inducing aftertaste. Cigarette butts, chewing gum, scratch cards, 'strong in alcohol' lager cans, used 'rubber Johnnies', a cold half-eaten chicken chow mein — the Still Life of the inner city.

Housing lists and the queue for rehousing — it's a greasy pole, a very greasy pole. God is not the only one to work in mysterious ways, so does the Allocations section for local housing. To get to the top you have to be a career complainer, a Ninja whinger, a get-under-my-skin-until-I-scream-with-irritation, the scabetic super moaners who have irritated their way to the summit.

How many stairs can you manage without getting breathless? How many dog turds can you jump over while holding your breath? Do you black out in the lifts if you cannot hold your breath for more than 90 seconds? How long can you hold your breath without the help of another person? Do you blackout when hit on the back of the head by a spanner with the help of another person? Can you abseil safely from your bedroom window when the delinquents on your landing set fire to the old carpet outside number 52? Do you get confused by the flat numbers? Yes. So does the postman — no wonder so many hospital appointment letters go missing. Can you grow magic mushrooms in the damp on your living room walls? Do you experience challenging behaviours from your neighbours on more then four consecutive nights in any given week? Do you need to establish a base camp on the second floor and then need oxygen to make it to the seventh floor? Do you need the help of another person to administer the oxygen? If you answer yes to any of the above then you are in with a chance. Including any of the above in a letter from your doctor will gain more housing points. And as we all know points win prizes.

I arrive at the door of my destination. More bolts and chains are unlocked than in a Hammer Horror feature. I enter and am immediately blinded by the golden glow of sunlight reflected from some immaculate parquet flooring and then come face to face with the widest TV screen I have ever seen.

'Afternoon Doc.'
'Good afternoon.'

Home visiting — chore or privilege?

Neil Douglas

The inner confrontation

CONSULTATION models have never really grabbed me. As a 'refugee' from secondary care in a speciality that required more than a modicum of sensitivity (haematology), I was confident when approaching general practice that being a 'good listener' and having a more than adequate 'bedside manner', at least when compared to the average orthopaedic surgeon, were attributes that would easily equip me for the task in hand. Thus, consultation models seemed a bit extraneous and unnecessarily complicated, not to mention rather boring. At a time just before the introduction of Summative Assessment and videoing for the MRCGP, I had the luxury of not having to pay more than lipservice to this particular aspect of the training. Pendleton — too tedious; Neighbour — too ethereal; Balint — too tree-hugging.

In fact, for reasons of vanity, laziness and the fear of being found out as a total impostor, I had managed to avoid being videoed ever, even in medical school. So it was with some trepidation when, several years later, I watched my efforts to convince the authorities that I was fit to be a GP trainer. Being enormously pregnant at the time and wobbling precariously in front of the camera like a small hippo on roller skates, I had hoped I might distract the viewer from any major mishaps or glaring inadequacies. However, after a while I realised that I wasn't so inept: clinically competent, sociably pleasant but hopeless at getting the punters out of the room. So, not a bad learning experience after all.

Three years on, I relived the experience while auditioning for trainer reapproval. Now I considered myself well versed with, at least the MRCGP video criteria after 2 years of excruciatingly navel-gazing tutorials on the subject with such gems as 'An existential approach to cues ('Just what the hell is a cue anyway?'), 'The metaphysics of sharing options' ('Real docs don't share') and 'Eschatology and end games' ('Saying goodbye the ejector seat way'). Videoing the surgeries was pretty awful, but watching the action replays was frankly embarrassing. Had I ever really been to medical school? Why was I looking at the computer screen all the time? 'No, you're not having sleeping tablets', is hardly patient-centred and there were more missed cues than in a one-armed snooker game.

So where had I gone wrong or had I just become more critical of my performance? Besides, learning how to do something 'properly' helps one to decide, with experience, which cues to miss and which symptoms to shelve for a later date; who needs the 'doctor-centred' approach and how to survive a surgery. On the other hand, 'maturity' can make one blasé and it is humbling to discover that sometimes one doesn't even realise one is missing the point. So, another useful learning experience, if only to find out just how grim life is for our registrars who have to do all this 'for real'.

Talking of which, it must be a great relief for candidates to have 'eliciting cues' elevated to the status of merit in the new MRCGP performance criteria. More hours are wasted by registrars, and sometimes their trainers, trying to decide whether that was indeed a cue, and whether it was actually elicited or merely passively acknowledged. Even MRCGP examiners can't seem to agree, according to feedback from the examination courses. But if this basic skill is 'dumbed up', will it be seen as inessential to 'grassroots' consulting and lose its importance? Still, you can't have it all ways.

Still smarting from my reapproval ordeal, I decided to revisit our esteemed President's worthy tome.[1] I must have 'moved on' since my ignorant registrar days as I find I can now relate to a fair bit of it! The chapter entitled 'On having two heads' has cynically reminded me of another consultation survival technique: the sanity-saving, silent running commentary. Mine goes something like this: 'Doctor, I want to talk to you about my periods/IBS/PMS.' No, you don't, you need to get a life. 'Doctor, I don't know where to start …' OK, so let's get to the point and give you some Prozac®. 'Doctor, I think I've got ME.' Next!! 'Doctor, I'm so tired all the time (zzzzzz), Doctor? (zzzzzzzzz) Doctor? Wake UP!!!'

One day I'm afraid the wrong head will start talking, but isn't that called 'The Flash' or is it just plain 'getting struck off'? I hope I won't have to find out.

Alison Woolf

Two encounters

I struggled with writing my paper. Then I saw my patient, Mrs B, twice in 10 days and my perspective changed: same doctor, same patient, two encounters, different outcomes.

The first consultation was at the end of an afternoon on-call. I grimaced as I saw her name added to the lengthening list of my scheduled same-day appointments. Our new registrar sat in with me, getting his first experience of an on-call surgery in general practice. He had already seen me juggling the demand of seeing patients, taking phone calls, triaging late visit requests and jumping up to deal with queries from our practice nurses. A mood of pace and efficiency. Get it done, sort it out, put it to one side, clear the decks. I recognise the hangover from my days on-call as a hospital doctor: get through what is in front of you, because you don't know what else is following. When I see my next patient I don't know whether she's the last of the afternoon or whether she is the beginning of a mad run of late requests. It's only at the end of an on-call that you can look back and judge whether it was a quiet one or not.

Mrs B shuffles in. Chubby arms in short sleeves. Her eyes flick towards the registrar but she says it's ok for him to stay.

'I'm not right', she says.

I pick up my stethoscope and ask about her chest. She has a long history of asthma and chest infections and soon agrees that her chest has been a bit more unsettled recently. A quick listen through tugged clothing confirms an infection. I prescribe antibiotics and explain that if she is no better she should come back.

'I'm still finding it quite hard …'

I know what she is referring to. The sudden death of her husband 2 years ago … but … this is an on-call afternoon, I need to keep that pace up, stay ahead of the work and so I try to end the encounter:

'A bad infection like this can make you feel quite low and washed out. Why don't you come back soon and we can look at how things are going generally?'

My paper is based on my Master's dissertation. I interviewed doctors working in general practice and asked them about 'patient-centred' care. What did they understand by the term and what influenced whether they acted in a patient-centred way?

Mrs B returned to see me a week later. I wasn't on-call and there was no registrar. I was having a good day, visits had been light, I had managed to get home for lunch and I was running to time in my surgery.

'I'm still not right', she says quietly.

Her head is bowed, buried in her tense shoulders. Her eyes are dark and round; she has the puzzled gaze of a frightened child.

'I'm just not right.'

I nod. She continues.

'I really miss him. I still think about him.'

'It's been a while now', I add.

'Yeah, 2 years next week.'

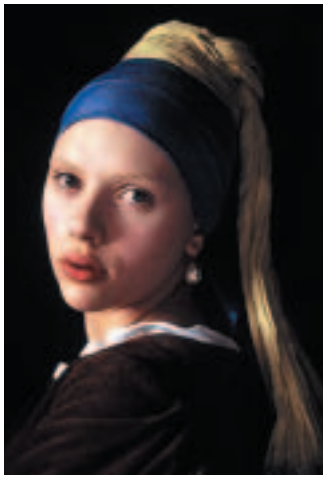
'The anniversary, the dates, it must be quite hard for you'

'It is'

For the next 10 minutes I listen. We don't talk about her chest.

My study found that GPs adjust their consulting style according to factors in and around the consultation. They may have a tendency to be more or less patient-centred,

Scarlett Johansson in Girl With a Pearl Earring



in brief

Two funny things happened in Lanarkshire general practice last week — a patient with dyspe anything to do with **Hector Pylon** — does the eminent gastroenterologist **Herr Professor H** elsewhere with the registrar for **scarlatina** (honourable purposes, honest, Guv) brings up **Sc** hearted and is educational in all sorts of unnecessary ways.

Bringing us, laboriously, to **Scarlett Johansson** who is everywhere. In *Lost in Translation, G Perfect Score.* She's a new star and we need them. In LIT her director, Sophia Copolla watcl real mystery, in the background, is Tokyo, a truly foreign place, beautifully evoked. In GWAPI Vermeer — beautiful cinematogaphy, up for an Oscar, as it should be.

So to marine biology and oceanography, a final frontier — our knowledge base is thin. Very t copepods are more important than ozone layers and Amazonian rain forests, but we know lit *Shrek*) starts the ball rolling: *The Blue Planet* (BBC, on DVD) inspires. *Trawler,* by Redmond why fishing need not be evil. Leading on to the key text — *Great Waters — an Atlantic Passa* £10.95 0 393 32334 X).

but all my GPs describe shifting their approach according to the context of their encounter with a patient. Very patient-centred doctors become less so when they are running late or on-call or when dealing with a patient with a serious illness. A less patient-centred doctor will become more patient-centred if given more time to consult, or if faced with a patient in emotional distress. GPs adjust and respond. I concluded that such a dynamic and contextual adjustment could best be understood from a narrative viewpoint — the consultation as the interaction of two subjective stories.

I want to write this up. The proper scientific way would be as an academic paper in a peer-reviewed journal. But I struggle to do it. I know the convention. A qualitative paper in a mainstream medical journal still needs to be based around the familiar sections of introduction, methods, results and discussion although I can use selected quotes from the GPs to illustrate my findings. As I write my paper in this form it all seems wrong. My findings seem dull and grey. The story is bled of colour, disconnected.

Then I see Mrs B in my two encounters and I feel the richness of my study findings. Same doctor, same patient, different context, different outcomes. As I reflect on what happened I realise that I make sense of my own situation by re-telling it as a story: 'on this day she came, I felt this, that happened; on another day …' Telling the story helps me to understand the dynamic and contextual adjustments I made as GP. I reconnect with my study.

Then I see further: my conclusion that the adjustments GPs make in their consultations are best understood from a narrative perspective is itself best presented in a narrative way. The story becomes the way of reporting my study findings.

Antonio Munno

psia wondered whether his symptoms could be
Pylon have his own website? Searching
arletWomen.com which is not for the faint-

rl with a Pearl Earring, and, less perfectly, *The*
es her inscrutably and obsessively, though the
Scarlett is similarly watched, this time by

hin. In biomass terms phytoplankton and
e about them. *Finding Nemo* (though sub-
O'Hanlon goes further and begins to explain
ge (Deborah Cramer, Norton 2003, PB 442 pp

Alec Logan

neville goodman

BD to the death

On Mondays the *Guardian*'s tabloid section is *Media Guardian*. From it, I learned that the top astrologers (pardon me while I choke on that) earn upwards of £500 000 a year courtesy of their newspaper columns. Some of the dosh comes from the phone lines they advertise there, but a fair amount of it is earned from writing the column. I got righteously annoyed when I first read this, but could you write nonsensical garbage that people nonetheless believe to strict deadlines day after day? It's quite a skill, and I don't have it.

Unlike the Barefoot Doctor, the *Observer*'s resident alternative therapist. His recent columns have been more spiritual and less medical of late, but rubbing kidneys still features, and when a lady wrote to him worried about her splenectomy he gave a splendid explanation of how the pancreas takes over. Orthodox medicine is simply helpless when faced with this guff, and Barefoot laughs all the way to the bank: his books were prominently on sale at bargain prices (although sadly not remaindered) in local bookshops at Christmas.

By a complicated chain of information that started with *Fortean Times*, via an enthusiastic collector of comics Chris Johnstone, I was directed to an on-line discussion with Barefoot (http://talk.guardian.co.uk/WebX?128@@.685e9480). The *Observer* started this at 15:58 on October 1 2003, and the first question rolled in at 15:01 on October 7. I was expecting more on the lines of the queries they publish in his column (Q: I've had a furred tongue for some time: what should I do? A: According to Chinese medicine, the tongue is governed by the left ear. Stretch the pinna out in a fan shape and wave it up and down 33 times …).

How wrong I was. The first query came from Sammy, who asked, pertinently: 'Do you really believe everything you recommend or do you think 'Lumme, I've no idea, you're probably dead meat' and then recommend a good rubdown with a spiritual pebble or something because that's what you DO.'

Just 3 minutes later TommyDGNR8 asked, 'Given that 95% of what you preach is superstitious nonsense and that the *Observer* effectively pays you to plug your products (available at an incredibly over-inflated price at a Boots near you!), how do you sleep at night?'

And so it goes on. It's a breath of fresh air. But the *Observer* is still employing him. Because there are people like Cherrie, who asked, 'When I read your column I often find it inspirational. However, how do you cope with all the criticism?' And lanky1 answered, just 1 minute later, 'He just counts the money Cherrie.'

our contributors

Some IT problems as this issue goes to press, so apologies to the likes of **Neil Douglas** for a lack of advance warning ...

Mike Fitzpatrick is a GP in north London and author of *The Tyranny of Health*. Google-ing him (dr mike fitzpatrick mmr) reveals (in 0.09 seconds) 190 refs and four sponsored links to purveyors of single vaccines. Which is rather ironic.
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Neville Goodman is allowed to write about the Barefoot Doctor on a strictly rationed basis. Like fishing for haddock, perhaps ...
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David Jewell edits the *BJGP*, in case you haven't noticed.

Thrusting cultural dynamo, **Toby Lipman**, is still surprised that Liverpool, and not Newcastle, is European Capital of Culture, whenever. He provides an excellent visitor service at:
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Peter Toon has eschewed the fleshpots of UCH for a quieter time in Canterbury.
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Slim-line **Colin Waine** is a member of the National Obesity Forum and Visiting Professor for Primary & Community Care at the University of Sunderland.
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James Willis hasn't written anything for this issue, but he is the new grandfather of the world's best baby, and Congratulations! Still space available at the (excellent) Bournemouth Spring Meeting, by the way ...

Alison Woolf is a GP in the leafier parts of Cardiff, owns a 3 year old, and is a famous cook. She worried that being disrespectful about *The Inner Consultation* would debar her from further commissions from the *BJGP*. This of course will not be the case. But will the GMC be so accommodating ...?
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dougal jeffries

Safe at sea

I last trespassed on these columns 3 years ago, when I came to the Isles of Scilly to be interviewed for a partnership. I described the mixed delights of venturing across the choppy sea to the island of Tresco on the medical launch, in the care of its coxswain and his dog Scout. I am pleased to report that I got the job, that I love the life out here — and that we have a new launch.

For as long as there has been a medical service in the islands, the doctors have relied on the use of a local boat, paid for largely through a local charitable trust and supported by a contribution from the practice. But as the expectations of residents and visitors rose, so we became increasingly aware of the shortcomings of this form of transport. The small launch had a tiny cabin forward of the steering house, not big enough to accommodate a stretcher. Anyone using the latter had to be strapped across the engine hood (after first removing Scout, who coveted its cushioned warmth), protected from the elements only by a somewhat leaky canvas cover. In rough seas the boat could be frisky, and at low tides her draught was too deep to dock at some of the off-island quays and ran the risk of her running aground between the islands. As for equipment, a first aid box and a folding chair — together with whatever gear the doctor or ambulance technician took aboard — was about it.

So, with Health and Safety legislation and public opinion looming large, my senior partner Toby Dalton and his colleagues on the Medical Launch Trust took it upon themselves to find a better solution. Happily, the West Country Ambulance Trust was persuaded to take on the responsibility of providing emergency transport between the islands, and after a prolonged gestation — with many revisions of the expected date of delivery and of the eventual birth weight — the fruits of their collective labour arrived safely in October 2003. She was christened 'Star of Life'.

She is a striking construction: some locals are still reluctant to call her a boat. For reasons of visibility the Ambulance Trust insisted that she should be painted in bright yellow and green livery. The large cabin resembles the back of a land ambulance, with a stretcher bay, neat rows of boxes and alcoves containing instruments and sets for various emergencies; piped oxygen and Entonox®; and blankets, ropes, torches, whistles and so on. There's probably a Swiss Army knife somewhere. The islands' ambulance technician, also clad in green and yellow, scrupulously maintains the gear. The coxswain refuses to wear a uniform. He sits at a very flash dashboard with an array of navigational aids, and Scout, disdaining the notice that says, 'In the interests of hygiene, dogs are not allowed in the cabin', has appropriated the footwell beside his master as his usual station, although sometimes he will curl up in the bucket seat intended for — who knows? — the master's mate.

The steel deck conceals two powerful waterjet engines, which can hurl the boat along at up to 24 knots compared to her predecessor's top speed of 15 knots, and can be manoeuvred to achieve remarkably sudden changes in direction and speed. Her clearance is about 15 inches, which means fewer delays and alterations as a result of unfavourable tides and sandbanks. And she is very solid. In fact, so sturdy and rounded is her hull that the Methodist minister who performed the naming ceremony mistook her bow for her stern, incidentally confirming the sentiments of the sceptical old Scillonian salts in the audience.

So now we have a safe, fast, well-equipped and comfortable water ambulance. And am I happy? Well, yes and no. I miss the grace of the old boat, whose movement in the waves seemed more like that of a living being; the new one feels and sounds like a bus on water, and moored in the harbour next to the lifeboat she's something of an ugly, if colourful, duckling. I resent the insistence that, just because we are on board the property of an official NHS Trust, we should wear a lifejacket at all times (well, no, since you ask). And I feel a bit of a Charlie turning up for a routine afternoon surgery on a sunny summer's afternoon in a vehicle that suggests I am about to perform a major disaster exercise. On the other hand, if I want to take my bike with me for a home visit or for crossing an island from one quay to another, no longer will it be thrown wildly around the deck and saturated with salt spray. It can be stowed next to the stretcher trolley in the warm dry cabin — at least until the Ambulance Trust gets wind of it and posts another notice on the wall.