The Back Pages

viewpoint

Come back when your kidneys are worse and we'll cure your pancreas …

LAST summer I learned that I had kidney failure and since then I want desperately to become ill rather than stay well. The kidney failure is due to diabetes, which I have had for 27 years. I used to feel depressed when blood tests showed a high sugar level, but now I am depressed when the same, unmoving creatinine level indicates stability. The reason for such perversity is that I have to get worse before I get better.

The solution to my problem would lie in having a new pancreas and kidney, but my kidney function is too bad for a pancreas-alone transplant and too good for a joint pancreas–kidney one. So I am stuck, caught between a rock and a hard place. The irony is that while the kidneys are stubbornly resilient other diabetic complications have been devastatingly rapid. During the past 2.5 years I have lost most of my eyesight, the process only halted by the remarkable skill of the surgeons at Moorfields Eye Hospital. I suffer from peripheral neuropathy and, for the past few months, femoral amyotrophy making walking awkward and painful. My fear is that the next complication will be cardiovascular, ending all hope of a transplant no matter what state my kidneys are in.

My frustration is shared by the doctors looking after me. They are bound by the regulations regarding kidney transplantation that require a patient to reach a certain level of failure before being admitted to a waiting list. I find it hard to accept that the rules for kidney transplants are also applicable to people like me needing both organs. Why is the decision not made from the perspective of the damage caused by diabetes rather than the state of my kidneys which are destined to fail completely anyway? I understand that the demand for kidney transplants outstrips supply and I am not suggesting that my case is more deserving than anyone else's. It just strikes me that the rules are unfair.

This powerlessness is at times overwhelming and waiting to get on to a waiting list is one of the most difficult things I have had to face so far. At least when my eyes were so poorly there was always some new treatment or operation to try. This negative waiting is dragging me down, sapping my vitality and optimism. When I last saw the consultant nephrologist I asked him what was the point of striving for normal blood sugar levels or taking blood pressure medication? Surely what I needed was bad control so that my kidneys would fail more quickly. He calmly pointed out that hypertension would certainly damage my kidneys, but the potential risk of a stroke wouldn't help me get a new pancreas. He reminded me of what I already know, that the fitter I am in the run-up to surgery the better the outcome. Such advice only adds to my confusion: on the one hand I need to get worse, while on the other I still have to work at being healthy. Although I am tempted to stop medication, I am scared of taking such wilfully destructive action. I don't want to give up, but fiercely want to live.

I am bored with the tedium of being unwell. I have had 3 years of it and want to get on with my life now. That is why the thought of a transplant is so exhilarating and the wait so debilitating. I have lost a lot in the last few years. Most importantly, my career and the chance to adopt a child. I worked as an LEA education advisor and an essential element of the job was observing teachers and children. I am piecing together a new career as a storyteller and education consultant, but it is impossible to plan very far ahead. The autumn my condition began to deteriorate I had nearly completed the process to adopt a child. My social worker was confident that I would be approved by the adoption panel. Earlier last year, I resumed the process and until the diagnosis of kidney failure, believed that visual impairment wasn't going to stop me becoming a mother. Now my only chance, and it is a very slim one that is becoming more remote as the months drag by, is to have this transplant.

I try to hold on to this dream while turned inward watching for the minutest signs of change in my unreliable, diseased body. I try not to let this infect my outlook on the whole of life, keeping faith with the promise of a future free of diabetes.

Jo Hopkins

The huge challenge facing UK general practice will be to retain and rediscover the true gold of the generalist medical tradition within the altered contractual context ...

Iona Heath, on the New Contract, page 320

Why not let public health activists set up their own clinics — 'worried well centres' — in which they can provide 'check-ups' and screening tests, carry out health promotion and lifestyle motivation projects, harangue children about junk food and drugs, preach safe sex to teenagers, nag everybody about smoking, drinking and exercise?

Mike Fitzpatrick, on a National Sickness Service, page 317

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news

Are animal experiments necessary in the 21st century?

The invitation to Joseph's Bookstore in London NW11, a spit to the south of the A1, to debate the necessity of animal experimentation in the 21st century billed Dr Ray Greek, an American physician, as 'the world's leading exponent of the devastating consequences for human health of experiments on animals' and Professor Colin Blakemore as the 'high-profile Chief Executive of the MRC.

It was an all-ticket affair and there was a palpable edge in the small bookshop where about 70 people had assembled on a near 0°C, clear-skied March night. Our MC kicked off; thousands had been turned away and only the chosen few remained. The evening was to start with 15-minute presentations from the floor from the two speakers and to be followed by questions. After this we would move into the adjacent Café Scientifique to enjoy meze and a glass of wine. It was hoped that we would produce 'light, but not too much heat' during the evening, even for the vegans in the audience.

Greek's arguments are straightforward. Animal experimentation has been an essential part of the scientific community for over 100 years, and as a direct consequence there have been huge advances. But it's a sloppy, dirty process that is fraught with difficulties; extrapolation of results from one species to another is dangerous. The first guinea pig injected with penicillin died; animal testing with thalidomide failed to demonstrate fetal abnormality. He argues that with DNA chip technology and Microdose PET scans (that detect tiny fractions of molecular activity), animal experiments are obsolete. End of story. No mention of animal suffering. No sentiment.

Blakemore argues that animal research exists to reduce toxic effects in humans and to enable greater understanding of physiological mechanisms. He emphasises that its role is small (20% of the MRC budget) and he disarms us by suggesting that 'The Real Question' is how can we minimise animal suffering? Perhaps a little sentiment here, but no tears visible in the auditorium.

There were few squeals from the floor, no snorts or catcalls from animal right's campaigners, no chantings from the terraces ('Who are ya, who are ya?'), just a few polite questions and just the hint of the beginnings of a spat between Ray and Colin. And then it was meze and muscat. As a dedicated West Bromwich Albion supporter, I am used to the low scoring game and this was a 0-0 draw. Blakemore and Greek sing from the same biomedical hymnbook.

Jim Hardy

Autism into Work

The National Autistic Society (NAS) is holding a 1-day conference titled *Autism into Work* on Thursday 22 April 2004 at the Quadrangle Conference Centre, Oxford.

Currently the opportunities afforded to people with autism to use their skills in the workplace are limited by the perceptions of employers and the lack of proper transitions from education into work. This conference will examine some of the transitional supports needed and examples of successful initiatives across the range of autistic spectrum disorders. Julie Moynihan, regional coordinator for The National Autistic Society in the South-West will chair the conference. Speakers include James Graham, The Interact Centre, London, Thomas Madar, Individual with Asperger Syndrome, and Catherine Burkin, Prospects Employment Service of The National Autistic Society.

Delegate places are priced at £99 plus VAT (£116.33 inc.VAT) for professionals and practitioners and £60 (£70.50 inc. VAT) for parents. The closing date for bookings is 15 April 2004. Booking forms can be obtained from the NAS Conference and Events department on 0115 911 3367 or **conference@nas.org.uk**

http://www.dermanities.com/

Welcome to *Dermanities*
Thank you for visiting the brand new *Dermanities* Journal. We hope you stay for a while and explore what we have to offer. Our focus is the humanities and medicine, with a primary focus on the practice of dermatology. We hope to fill a need currently not addressed by other medical journals. Please bookmark this page and visit us often and join our mailing list.

Anxiety Disorders Conference

Specifically For Those Dealing With Anxiety 13–14 November 2004, Manchester

Frank Tallis, Professor Cary Cooper CBE and leading researchers in anxiety disorders will be providing talks and workshops aimed at individuals with anxiety at a major conference later this year in Manchester. The event, which takes place over the weekend of 13–14 November at the Manchester Conference Centre, is being organised by a new charity, Anxiety Disorders Conference, and aims to explore the latest research and best treatments available for conditions such as panic, anxiety, phobias, post-traumatic stress disorder, obsessive compulsive disorder (OCD) and related disorders with those who suffer from these conditions, their friends, families and therapists. Contributions from inspirational speakers who are recovering from anxiety will provide a key element to the weekend's events.

Speakers include Professor Cary Cooper CBE, formerly Head of Organisational Psychology and Health at the University of Manchester, Institute of Science and Technology and now of Lancaster University Management School; representatives from NICE, on the draft NHS guidelines for the treatment of anxiety, panic and OCD; author and psychologist Dr Frank Tallis will ask whether love can be classed as an obsession. Specialist workshops will be run on worry, panic attacks, agoraphobia, social phobia, flying phobias, vomit phobias, health anxiety, body dysmorphic disorder, obsessive compulsive disorder and trichotillomania. People who have or are recovering from such conditions will tell their stories.

For more information contact Alison Potts at:
alison.potts@lineone.net
or, Anxiety Disorders Conference on:
0161 232 0163
(Registration from August)
Website live in March:
www.anxietyconference.org.uk

Academic window-shopping in Glasgow

THE Annual Scientific Meeting of the Society for Academic Primary Care is the principal shop window for academic general practice and primary care in the UK. The 33rd such conference takes place in Glasgow on 14–16 July 2004, with the theme *Work In The Future — Making A Difference*. This year the conference will have three special features, in addition to the usual Glasgow hospitality.

First, the three plenary speakers comprise the three 'R's. Dr David Reilly, internationally-renowned physician in charge of the Glasgow Homoeopathic Hospital, will open the meeting with an address on holistic consultations — how tuning into the patient can unlock innate powers of healing. Professor Martin Roland, Director of the NCPCRD at Manchester and provider of much of the academic input underpinning the quality component of the new GP contract will talk on *Quality of Care — the next frontier*. Finally, Dr John Reid MP, Minister of State for Health, and the government's own general practitioner (in view of the number of posts he has held), will give the view from Whitehall.

In addition to over 100 scientific presentations, there will be six large workshop sessions to engage a wide group and to make a difference in an important area.' Workshop topics are:

- Setting standards for teaching practices — Phil Cotton *et al*
- Using computerised primary care data for research — Azeem Majid *et al*
- Beyond depression — re-directing the medical gaze — Chris Dowrick *et al*
- Epidemiology of primary care — Blair Smith *et al*
- User involvement in research — Fiona Ross *et al*
- Vive la difference! (multidisciplinary working) — Elspeth Mclean *et al*

There will also be over 100 posters, and a novel feature will be the commitment to subject every poster to peer review and commentary in parallel sessions. Prizes will be given for the best oral and poster presentations. To the above, add the reception in The Lighthouse, an evening in the city centre, dinner and ceilidh in the Bute Hall and 2 days of Glaswegian hospitality. To make this conference even more attractive, and responding to the discussion at last year's AGM, the registration fee has been pegged to £350. Book now (www.sapc.ac.uk) to reserve your place at an ASM to remember. And for those interested in such things, the last 2 days of the Open Championship at Troon, or perhaps just the glorious scenery of the west of Scotland, are reasons to extend your stay for the weekend.

Graham Watt

flora medica theophrastus bombastus

From the journals, February 2004

***New Eng J Med* Vol 350**
586 What's the difference between erythema infectiosum, slapped cheek syndrome, and roseola infantum? Answer: the first two are the same, and are caused by parvovirus 19 (thoroughly reviewed here). They are known as fifth disease, while roseola is sometimes known as sixth disease.
647 The cardiac ventricles tell us when they are feeling overstretched by secreting B-type natriuretic peptide — so measuring it is a good way to tell whether acute breathlessness is cardiac or not: it's also a good predictor of whether people are going to die (page 655).
694 You might suppose that islet cell transplantation is the very latest idea for curing diabetes, but people have been trying it for 110 years — and still with little success.
757 When excising a deep malignant melanoma, a margin of 3 cm reduces local recurrence — but does not affect survival.
777 Having a premature or small-for-dates baby increases the risk of a subsequent stillbirth.

***Lancet* Vol 363**
465 Why read another review of otitis media? Because this one goes deep into the causation and even holds out hope for future treatments that may be less useless than antibiotics.
545 This review of sexually transmitted diseases is good too — don't miss figure 1, a classic of 1940s health promotion.
600 How would you like a near-patient test that can distinguish between viral and bacterial respiratory tract infections? Procalcitonin looks promising, but needs a lot more work in primary care.
675 Blocking the effects of tumour necrosis factor alpha can be dangerous, but can bring dramatic benefit in some chronic inflammatory diseases — an example is etanercept used to treat rheumatoid arthritis. In this trial, adding methotrexate brought further benefit.

***JAMA* Vol 291**
585 C-reactive protein was first described over 70 years ago, but we are still learning about it. Not only are raised levels a predictor of cardiovascular events, but this study shows that there is an association with colorectal cancer.
605 If you are confused by the growing range of new drugs for the control of epilepsy, here is a clear and comprehensive review.
827 The trouble with associations is that they don't prove causation — as in this well-publicised case-control study showing a relationship between antibiotic usage and breast cancer.
866 Subarachnoid haemorrhage is a diagnosis we should try harder never to miss, because this study shows that rapid diagnosis does improve outcome.
947 The optimal treatment for myocardial infarction is immediate reperfusion: this study shows that if there is a delay, the drug to use is abciximab and not a thrombolytic like reteplase.
955 Should blood pressure be measured at home or in the office (surgery)? A Belgian primary care study shows that home measurement results in less treatment, but we lack information about long-term hard end-points.
974 Getting the maximum number of publications out of the same study is a highly developed art, according to this interesting analysis of duplicate publication.

Other Journals
Arch Intern Med (**164:** 313) repeats the old message: it you don't put your finger in it, you'll put your foot in it — and oddly enough female practitioners do more prostate examinations. Hyponatraemia in the elderly is often a puzzle — but paroxetine is sometimes the culprit (page 327). *Ann Intern Med* (**140:** 157) looks at aspirin use in the Nurses' Health Study and confirms that it does protect against colorectal adenoma. Less well known is the fact that alcohol protects against diabetes mellitus (page 211) as well as its complications. For those interested in diagnostic studies, there's an indispensable review of sources of variation and bias on page 189.

So far from helping the symptoms of gastro-oesophageal reflux, eliminating *Helicobacter pylori* actually worsens them (*Gut* **53:** 174). Those who believe in the Polypill idea will draw ammunition from a study in *Circulation* (**109:** 745) which shows that the benefits of cardioprotective drugs amount to more than the sum of their parts. There is a persuasive systematic review in *Thorax* (**59:** 94) showing that written treatment plans for asthma make a real difference. If you thought that squawks were just a feature of baby clinics, there's a letter (page 177) telling you to listen for them in the chest as a sign of pneumonia.

Finally, from the *Int J Cosmet Sci* (**26:** 37), news that scientists are working tirelessly to detect and defeat body odour.

Plant of the Month: Magnolia 'Butterflies'
Fancy a yellow-flowered magnolia? This one grows better every year, sprawling and covered in scented flowers.

How much of general practice is based on evidence?

ONE often-voiced argument against evidence-based medicine is that clinical practice is, in fact, not evidence-based. The origins of this argument lead us to a *BMJ* editorial of 13 years ago,[1] referring to a remark made by David Eddy, at a conference in Manchester, that only 15% of medical practice was based on any evidence at all.[2] Dr Eddy apparently based this figure on his studies of two conditions, glaucoma and peripheral arterial disease, and similar figures had already emerged from studies conducted in 1960 and 1961.[2] But how much of today's general medical practice is based on evidence?

The most conclusive answer comes from a UK survey by Gill *et al* who retrospectively reviewed 122 consecutive general practice consultations.[3] They found that 81% of the prescribed treatments were based on evidence and 30% were based on randomised controlled trials (RCTs). A similar study conducted in a UK university hospital outpatient department of general medicine arrived at comparable figures; 82% of the interventions were based on evidence, 53% on RCTs.[4] Other relevant data originate from abroad. In Sweden, 84% of internal medicine interventions were based on evidence and 50% on RCTs.[5] In Spain these percentages were 55 and 38%, respectively.[6] Imrie and Ramey pooled a total of 15 studies across all medical disciplines, and found that, on average, 76% of medical treatments are supported by some form of compelling evidence[2] — the lowest was that mentioned above (55%),[6] and the highest (97%) was achieved in anaesthesia in Britain.[2] Collectively these data suggest that, in terms of evidence-base, general practice is much better than its reputation.

The question therefore arises why misleadingly outdated figures are still cited regularly. Ignorance is, of course, one explanation. Closer scrutiny, however, suggests another reason. The misleading figures are not provided to stress that our efforts to strengthen the evidence base in medicine should be increased. They are provided as an argument to integrate unproven therapies into routine healthcare: if conventional medicine is not evidence-based, it is unfair to demand evidence from unconventional therapies. The Chair of the NHS Alliance recently expressed this as follows: 'People argue against complementary therapies on the basis of a lack of evidence. But I'd say only 10 per cent of what doctors do in primary care is evidence based'.[7] This argument is akin to saying that, if thousands die on the roads each year, it is alright if our trains are unsafe too. Its application would clearly weaken the evidence base in medicine.

But does evidence-based health care generate real benefit? It is difficult to answer this question conclusively; the logistical and ethical problems are insurmountable for conducting RCTs to establish causality between a general evidence-based approach and health-related outcomes. But we do have

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significant amounts of indirect evidence in specific areas covering anything from asthma to unstable angina.[8] And this evidence clearly suggests that applying the principles of evidence-based medicine to healthcare results in improved outcomes. We also know that most family physicians welcome evidence-based medicine and use it wisely — as one of the several factors involved in clinical decision-making.[9-11] Essentially evidence-based medicine can inform us what treatments are effective but not necessarily which patients should receive them.[12]

In conclusion, the pessimistic estimates suggesting that only 10–15% of general medical practice is based on evidence are as prevalent as they are outdated. In recent decades, evidence-based medicine has made significant progress so that most of general practice is now solidly based on evidence.

Edzard Ernst

mike fitzpatrick

National 'Sickness' Service

THE public health manifesto produced by the former banker, Derek Wanless, and formally submitted to the Prime Minister, the Secretary of State for Health and the Chancellor of the Exchequer in February, proposes a radical shift.[1] According to Wanless, we need to abandon a National 'Sickness' Service based on a 'medical model of avoiding ill health and disease', and adopt an approach based on 'maintaining and promoting good health and quality of life'.[1]

Let's leave aside the point that this radical modernising proposal is remarkably similar to the conception of the NHS advanced by Beveridge and Bevan in the 1940s. We'll also draw a discreet veil over Wanless' anticipation that the healthier population, resulting from the implementation of his policies, will make less demands on the health service and thus allow future reductions in government spending on health. In 1961 one illustrious former health minister, Enoch Powell, referred to this assumption — shared by the founders of the NHS — as 'a miscalculation of sublime dimensions'.[2] Let Wanless — or any health minister who is guided by him — rediscover what has become known as 'the Beveridge fallacy' in honour of the progenitor of the welfare state.[3]

I would like to suggest that what we need is a high quality national sickness service, and that this could be best achieved by separating the sphere of public health from the work of doctors and nurses in hospitals and surgeries. Why not let public health activists set up their own clinics — 'worried well centres' — in which they can provide 'check-ups' and screening tests, carry out health promotion and lifestyle motivation projects, harangue children about junk food and drugs, preach safe sex to teenagers, nag everybody about smoking, drinking and exercise? The private insurance companies have successfully sold such clinics to corporations and their employees: why not extend the BUPA model to the nation?

I doubt whether 'worried well centres' would make much difference to either the duration or quality of life. But, as Wanless says, 'the lack of conclusive evidence for action should not, where there is a serious risk to the nation's health, block action proportionate to that risk'.[1] Or to put it another way, if a particular policy fits the government's ideological agenda, it is not necessary to produce evidence of its effectiveness. Notions such as 'prevention is better than cure' and 'early diagnosis promises better prognosis' have a powerful appeal; unfortunately, in relation to much contemporary disease, notably coronary heart disease and cancer, they are not strongly supported by evidence.

Although the new public health manifesto may not promise much in terms of health, it has a great appeal to politicians who are desperate to restore prestige and authority. Indeed, we see in the Wanless report the residue of social engineering projects inherited from exhausted political traditions. The old left once envisaged removing inequalities in health, either by abolishing the class system, or by reforming it through the redistribution of wealth and the provision of state welfare. Now New Labour aspires to reduce differentials in health status by cajoling working class people into middle class behaviour in relation to diet, exercise and smoking. The old right — particularly its evangelical/clerical wing — once believed that it was possible to moralise the poor into giving up deadly sins such as gluttony, sloth and, most of all, concupiscence. Now New Labour seeks, in a non-judgemental way, to promote virtuous — healthy — lifestyles. The old welfare state and old-time religion may have gone, but the new order offers 'cradle to grave' counselling to 'support' sinners in staying on the path of righteousness, now redefined as 'making appropriate lifestyle choices'.

The great benefit from the establishment of 'worried well centres' would be that it would allow the rest of us to get on with our work of diagnosing and treating illness and disease, without also having to carry the burden of lifestyle policing and moral surveillance.

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postcards 2003–2004

Old Masters and new technology: a postcard from three countries

DURING the course of last September, which was my 21st in practice and my 50th on the planet, I went to two conferences and one meeting. I want to tell you the story of these three events, and the way they have made me think about knowledge, professionalism and practice. I'll start in the middle, a meeting of the Old Masters group.

Old Masters

This is a small group of GPs that has been meeting in Leeds over the last 18 months. Having recently completed Master's degrees we were wondering where else we could find the interest and stimulation that our courses had given us. At the same time we were wondering what to do with the energy and enthusiasm we had gained.

Many of the group have experience in research and education, and this has been part of our personal development. However, from our perspective, formalised research and education, as embodied in university departments of general practice or primary care, do not seem to provide all that we are looking for. In fact the existing structures can be positively unhelpful.

Equally, in our every-day medical practice, we are aware of a gulf between the guideline-based implementation of health policy and the complex untidiness of patients' and practitioners' lives. We are thus in a position of regarding research, and its implementation, as a possible route for personal development, and as a possible route towards improving patient care. At the same time we are aware of the limitations that present structures place on both of these 'solutions'. These issues seem to us to be defining in terms of our own professionalism as individuals and also to the profession of general practice.

Some of our group are actively engaged in communities of practice, the application of complexity theory to health and social care, and the role of narrative in medicine. Within these fields there is a set of ideas that seems to offer possible ways of working across some of the boundaries that we face. We wonder what we can do.

Shared decisions?

At the start of the month I had been to the Second International Shared Decision-Making Conference in Swansea. My first visit to Swansea, my first shared decision-making conference.

The view of shared decision-making that I took to Swansea was that it is situated between the paternalistic model of 'doctor knows best', and informed choice 'here are the facts: you choose'. With my background in communication skills teaching, I relate shared decision-making to the consultation and ways of including the patient's conceptual framework in the process.

The dominant discourse of the conference was around the use of decision aids. Much government money, not least in the United States and Canada, is being used to develop tools, mostly computerised, that lead the patient, customer, end-user, through a decision. I felt myself uncomfortable with the discourse. The reason for this was crystallised by talking to other refuseniks at the conference: people more erudite and better known than me.

The train of thought is this:

- Sackett's vision of evidence-based practice, that the individual practitioner is empowered by the ability to critically appraise evidence and apply it, has been subverted to mean delivery of policy by practitioners.
- Having failed (so far) to get evidence (policy) into practice by leaning on practitioners, the authorities are now packaging policy for direct consumption by patients: by-passing the complex mess of the doctor–patient interaction.
- The new GMS contract feels to be another part of this same process: the pressure in the consultation now is not to be patient-centred but to be policy-(evidence) centred.

Communities and technology

And so, at the end of September, to Amsterdam for the First International Conference on Communities and Technology. My first trip to Amsterdam too. This conference was, gloriously for me, not medical. It was conceived as a conjunction between the new information and communication technologies, represented by serious Silicon Valley companies, and sociologists who are interested in the way these technologies are used, and how they shape social interaction.
My ticket there was my involvement in an international and multidisciplinary community of practice; sometimes we call ourselves an international research group. We ran an all-day workshop on the eve of the

main conference. We are all interested in facilitating groups and engaging with other people across boundaries (political, social and occupational). In 2002, after months of on-line work, we had met up in Portugal for a few days. I've been through the mills of postgraduate medical education, and am firmly wedded to the value of in-the-room face-to-face group work. Before the trip to Portugal I had been astounded by how much tacit and emotional stuff can be communicated in on-line groups. Reinforcing this with face-to-face work, then returning to computer-mediated discussion was extremely energising and productive: more so than any group work I had previously encountered. The synergy was strong enough to bring some of us back together, from three continents. In the workshop we told stories of our experiences the previous year as examples of how alternating on-line and face-to-face communication works. At the same time we were forming a new group and taking the process forwards by another turn of the spiral.

The main conference was traditional: addresses from stage and podium, speakers hiding behind microphones and PowerPoint slides, audience passive apart from short question and answer sessions. The discourse was formal and academic. Our efforts to engage the speakers with the audience were applauded by some, treated as subversive by others, and caused offence to a few.

Two of our group presented a paper, about context and computer mediated communication; this was dismissed by a 'questioner' because the word 'context' was used differently to the way she was sure it should be used. This was a seminal moment: at first it made us feel like outsiders and amateurs. On reflection it clarifies the distinction between creative sense-making through practice and conversation on the one hand, and meaning defined by authority on the other.

Now what?

Over the last 2 years I have experienced the power of combining computer-mediated and face-to-face conversation to help diverse people understand each other's world-view and to talk the same language. By this I don't mean that we all talk English, I mean that we attach the same concepts to particular words and phrases. But where do I take this: where does this take me?

First, the meeting in Leeds made me think that perhaps, after all, there is a way to combine research, practice, and personal development without having to change mind-set at every turn. Perhaps there is a way of allowing 'ordinary practice' to inform research? Perhaps there is a way to embrace innovation and diversity in general practice in the 21st century? There is work to be done to try to join up the worlds of education, practice, and research. There's a catch 22 here though: the approach may not be seen, from within academe, as valid until the work has been done. So who will fund it?

Second, one way of looking at the NHS is as a distributed organisation: distributed geographically, across trades and vocations, and across domains (e.g. primary and secondary care). Integrated electronic care records, to be introduced through the National Programme for IT from next year, offer a bridge across these divides. But how will they be implemented and will this communication channel used by so many different sub-cultures become a Tower of Babel? There is an opportunity to apply communities of practice technology and expertise here, to increase mutual understanding through conversation and story-telling, and with Alasdair Honeyman I am part of an attempt to realise this opportunity.

Finally, there is the recurring thought that behind my intellectual conceits I may be nothing more than a middle-aged misfit.

Wish you were here???

Paul Robinson

Why we need COPs to make use of evidence

We may have nailed our souls to the mast of evidence-based practice, but it is implicit knowledge, not external evidence, agreements or educational endeavours that usually determine what happens in the real world.

This paradox is why changing how we practice is so much messier (and more interesting) than the evidence itself. And why training is often so inefficient at delivering new behaviour. (Hands up anyone who learned more than 10% of the keystrokes required to operate their clinical system from their supplier.) So Paul Robinson's postcard (see the article next door) brings news from familiar territory: we may dream of fabled lands where everything is driven by contracts, evidence or policies, but to make anything actually happen we must continually negotiate with ambiguities, context and personalities.

Communities of practice (COPs) are the means by which we navigate all these implicit understandings. They are the collection of people, routines, concrete agreements and local fudges that enable things to get done and that define our sense of 'that's the way we do things round here'. My consulting style is a major definition of the community of practice that I have developed with my patients. Similarly, there will be a community of practice that deals with repeat prescriptions in your practice, one that is planning service developments across your health community and one that determines how the shopping gets done in your household. The key to effective change in organisations is understanding and changing the relevant community of practice.

Slowly we are realising the implications: on-site learning and discussion is much more effective than training courses. Communities of practice touch everyone without regard to status — so everyone needs to be involved. The informal folk world of gossip, implicit knowledge and the local work-around deserve much more attention than the protocol, policy and contract.

Paul Hodgkin

april 2004

'The cawing of the crow … Cassandra-like, prognosticating woe'[1]

The new UK contract for general practitioners (GPs) comes into force on 1 April 2004. Could there be a more appropriate moment than All Fools' Day — the day traditionally dedicated to exploiting the credulity of others? The contract threatens to fulfil Paul Foot's assertion that 'under New Labour the word reform always means the opposite'[2] and the government's success in using the word in this way is a testament to the enduring prevalence of credulity. The Fools' Day Contract promised more investment in primary care and higher incomes for GPs but these may prove to be fool's gold, glinting seductively but turning out to be illusory, and concealing a number of powerful agendas that may be working against the best interests of both patients and their doctors. The huge challenge facing UK general practice will be to retain and rediscover the true gold of the generalist medical tradition within the altered contractual context.

The new contract imposes changes that will serve to accelerate the fragmentation and privatisation of primary care and leave it open to commercial pressure in a manner unprecedented since the inception of the NHS in 1948. One of the greatest strengths of UK general practice has been the positioning of GP primary care close to the patient and at a distance from any institutional interest. This has served both to promote equitable accessibility and to enable trust. Patients and doctors need time and space to work together, to establish trust and then to negotiate the complex interactions between life stresses and illness, and the dangerous interface between illness and disease. It is all too easy for those made vulnerable by illness to be exposed to the dangers of scientific medicine rather than its benefits, and to be subjected to commercial exploitation fuelled by fear. NHS general practice has mostly eschewed private practice and has fostered strong traditions of care centred on the patient's own values and priorities, and of advocacy on behalf of patients. By these means, general practice has resisted both the privatisation and the medicalisation of health care. By providing care to everyone, irrespective of age or condition, and by accepting this responsibility 24 hours a day, 365 days a year, general practice has also resisted the fragmentation of care. This combination of resistance against medicalisation, fragmentation and privatisation has meant that the traditions of general practice have held back the commodification of health care within the UK and have slowed the development of the for-profit heathcare industry. All these traditions are threatened by the new contract and it is not difficult to detect the fingerprints of the World Trade Organisation and the huge financial muscle of the medical industrial complex lurking behind the simplistic rhetoric of reform.

The new contract breaks the formal link between a named doctor and a named patient — the commitment of one individual to another — and substitutes a contract between organisations. This simple change repositions GP care away from the patient and closer to institutional interest. GPs may feel themselves to be less accountable to individual patients and more accountable to primary care organisations and the public health agenda that they are designed to pursue. There has always been, and will always be, an irreconcilable conflict between the imperatives of the clinical care of individuals and the public health agenda for populations. Politicians and policy-makers must always put the needs of the population above those of the individual; the clinician, if he or she is to retain the trust of patients, must necessarily do the reverse.

The Trojan horse of the current raft of changes has been evidence-based preventive therapeutics and the ease with which honourable aspirations have been exploited in the interests of the pharmaceutical industry. Preventive technologies are responsible for a substantial proportion of the exponential increases in healthcare costs and also serve to divert healthcare expenditure away from the old, poor and sick towards the young, rich and well. Only a minority of most populations is acutely ill at any one time whereas the majority is healthy and susceptible to persuasion that they need to take action to remain so by undergoing screening or by taking a preventive medication. Clearly, from the point of view of the pharmaceutical industry, there is more money to be made from selling healthcare interventions for the healthy majority than for the sick minority.

The commercial imperatives of the pharmaceutical industry are assisted by the rapid developments in information and communication technology and by the hubris of medical researchers. Computers allow the ready identification of potential users of pharmaceutical products, and the routine exaggeration of their benefits strengthens the arguments for their use. The common practice of extrapolating into the future beyond the timeframe of the primary research and using formulae that value speculative future benefits over current need, further bolster potential markets.

Under the new contract, primary care organisations (PCOs) will fund and own all information technology equipment used in practices. Again, this is a fundamental change which, although financially

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advantageous to practices, risks the further erosion of their independence and autonomy. Primary care clinicians collect intimate personal information from patients in order to be able to provide care and, increasingly, this information is entered on computers in a very easily retrievable form, which is so useful that computers have become indispensable to high-quality clinical care. Practice computer systems are now linked directly to PCOs for purposes of payment and administration, but clinicians, let alone patients, have no real idea what information is being drawn down from practice systems, how and to what extent it is anonymised, and for what purposes it is used. This situation is making it almost impossible for GPs to fulfil their duty of confidentiality by ensuring fully informed and voluntary consent to the sharing of personal information. The Patient Information Advisory Group has already expressed its concern[3] and the new contractual framework may make matters worse. The original clause 472 of the draft Standard GMS Contract, stated that 'Under the Data Protection Act 1998, for the purposes of this Contract, the PCT is a data controller and the Contractor is a data processor.' The clause has now been withdrawn with no explanation, but one is left wondering about the apparent intention of transferring control of, and access to, personal medical records from the individual GP to the state.

Despite all these very serious problems, it is clear that the new contract also brings new opportunities. Primary care teams across the UK are reflecting on these and looking afresh at what they do, how different tasks are distributed among different members of the team, and whether the mix of different skills and qualifications needs adjusting or augmenting. Clinicians are reconsidering the content of consultations and struggling to find ways of incorporating the 1050 points on the quality and outcome framework scorecard, without the available time being entirely dominated by the agenda of the healthcare machine with none left for the fragile fears of the patient. Computer screens are beginning to flash up rafts of reminders, each carrying tantalising numbers of points, which are powerfully distracting, and clinicians will need to find new ways of retaining a proper focus on the patient and his or her immediate concerns. However, we are already beginning to see benefits. We are cajoling more patients about their smoking than ever before with considerable success, and the ongoing care of those with ischaemic heart disease, diabetes and other chronic illnesses seems certain to become more rigorous.

The danger is that any system based on this degree of incentive is likely to lead to the coercion of patients. Clinicians simply do not have the time to provide a full explanation of the pros and cons of all the various interventions, and the incentives are likely to mean that treatment of, for example, mildly raised blood pressure, will become the default option without proper explanation. If patients are to be appropriately involved in decisions about their care, GPs must press for the provision of decision support materials for each of the new contract indicators, so that patients are enabled to make decisions that are concordant with their own values and aspirations, and not ones that are simply dictated by the incentives, or even the population-based evidence, that underpin the indicators.

Those with more than one illness may be particularly badly served by the new contract and it is, of course, poorer people who are more subject to multiple and compounding illnesses and problems. Poorer patients are proportionally much more likely to have other supervening clinical priorities, or an excessive burden of medications or a mental health problem that undermines concordance — and are therefore highly likely to be disproportionately represented in the exception reporting under the new contract. Older people will also be disproportionately represented. Those who are listed as exceptions may well end up getting a lower standard of treatment than they do at present because most efforts will be focussed on those who figure in the targets. In this new and complex situation GPs will need to work hard to ensure that the new contract does not provide yet another example of the working of the inverse care law.

As blood pressure and cholesterol levels and fit frequency are driven lower and lower, there is a grave danger of the excessive use of medications with a rise in hazardous interactions and iatrogenic illness. GPs need to be prepared to scrutinise the shifting evidence base of practice and, remembering the HRT story, press for continuous adjustment of the quality and outcomes framework so that only indicators based on the most robust evidence are retained and the dangers of excessive medication are addressed. Clinicians will rely on the primary research community to evaluate the ongoing implementation of the contract and the playing out of its various perverse incentives.

Under the new contract, all practices will provide essential services and it seems likely that the vast majority will provide the additional services. However, enhanced services seem likely to prove problematic. Many within primary care have worked hard over many years to incorporate services for those with, for example, mental illnesses and problems of substance abuse within mainstream general practice, so reducing the marginalisation of those affected. With the new system of enhanced services, there is a risk that practitioners will be asked to demonstrate further qualifications in order to provide such services, which will act as a disincentive and undo all the successes of previous years. Efforts need to be directed at making the provision of enhanced services accessible to all practices, and PCOs should be pressed to provide the support necessary to make this possible.

Beyond all this, the new contract brings more fundamental opportunities for primary care to explore and develop new legal forms for its basic structure. The traditional unit of a practice, based on a partnership of doctors, has had a number of advantages of which the greatest has been its flexibility and relative independence. The new practice-based contract opens the door to replacing such partnerships with a variety of new legal entities including companies limited by guarantee within which directors would be voted onto a board by staff, or even by patients; community or public interest companies, which provide limited liability, the pursuit of socially useful ends, and the return of surplus value to the community; mutuals, which are based on the old building society model; and charities. All have the potential of deepening and extending the involvement of other primary care professionals and members of local communities within the organisation, financing and running of primary care, and may yet provide the means by which the traditional strengths of UK primary care can be protected (P Hodgkin, personal communication, 2003).

If the virtues of personal continuity, advocacy, inclusivity and universality are to survive, GPs will need to decide to retain responsibility for out of hours care, if not its direct provision, to keep their lists open and to devise ways of identifying a named GP for each patient. If GPs relinquish control of out of hours care, or any other aspect of what has previously been a cohesive service, the existing processes of fragmentation and commodification[4] are likely to be accelerated to the detriment of patients, undermining the discipline of general practice and threatening the survival of the NHS. A foolish outcome indeed!

Iona Heath

The Body in the Library — a literary anthology of modern medicine
Iain Bamforth (ed)
Verso, 2003,
HB, 418 pp, £25.00, 1 85984 534 7

THIS is not an easy book but many good things are not easy — Tristan for instance, and digging for gold.

The major difficulty for me was Iain Bamforth's introduction which I found opaque and obscure. This lasts 15 pages and it is hard work and I did not find it worth the effort. But don't give up — the gold is there further on if you dig.

The title is misleading. The book has nothing to do with detection nor dissection. Indeed, 'modern' medicine is somewhat misleading. Only a small part of the book is concerned with medicine since the second World War and only one or two pieces relate to British medicine since then. This is not a criticism, but it does mean there is little in the book to which a practising NHS doctor can relate. Iain Bamforth has — I believe — abandoned medicine. His selection of writings is largely bleak — and when not bleak, is black. Many of the pieces cast doctors in a very bad light, but maybe that is how medicine was once: peopled by poseurs, charlatans and the self-interested.

Still, I yearned for more writing to show that medicine could be humane and caring and there's very little of either in this anthology. I wonder why Iain Bamforth chose pieces so often cynical and self-absorbed when he could have included pieces from today showing a kinder face. There is nothing of Iona Heath or Iain Chalmers, both of whom have written powerfully about the humanity of medicine. Maybe Bamforth excluded them, their not being artists but doctors who happen to write.

But now for the gold among the blackness. Bamforth introduces us to many writers we — well I — have never met before with lively and helpful introductions. In particular there are over 20 pages from the diary of Miguel Torgas — a GP working in rural Portugal for 60 years, who would probably have remained almost unknown if Bamforth had not introduced the English speaking world to his work:

> *'Someone said to me today: "Dear chap, if you could be in the literary life what you are in the medical life — conciliatory, tolerant, ready to forgive it would be a marvel." The poor man had lost sight of the difference which exists between these lives, both sacred for me. As a doctor, I look after suffering brothers who knock at my door, to whom I owe love and assistance; but as a writer I fight against hypocrites, fat and in good health, who consider art a means of reaching grubby and unacknowledged ends?'* (page 258.)

Contributions from patients are few — Fanny Burney's description — before anaesthesia arrived — of her mastectomy in 1812 is terrifying but a tribute to her courage (page 16).

There are few moments of reprieve but Hebel's *The Cure* stands out (page 24). I have always believed it was wrong to lie to patients. After Hebel I'm not so sure — read it and decide for yourself.

There's a collection of Ronnie Laing vignettes including the funniest story I know associated with leucotomy (not in itself an amusing topic) — much helped if the reader can hear Glaswegian in their head (page 326).

Laing was a hero of mine when I was a student at UCH. I met him in Lewis's bookshop in Gower Street in 1974, a small apparently insignificant man of great humanity, unlike most — although not all, of my teachers at UCH. George Orwell must have come across similar doctors to the latter in Paris when he wrote *How the Poor Die* (page 212). Bamforth notes 'the cynical allegiance of doctors to disease — processes rather than the people who suffer them'. Oh, how that struck a chord with my student-self.

The book gets better as it comes to the present day — maybe medicine has become kinder and more interested in patients than self-glory. I hope so.

Two essays at the end stand out: Keizer on the death of his father — technology obscuring compassion (page 382) and Jonathan Kaplan helping the terrified (page 406).

The *BMJ*'s APOLLO CD-ROMs may teach modern doctors more humanity, but this book is a beautiful thing in itself and CDs are never beautiful — albeit it might have benefited from some illustrations.

This is a book for those interested in where medicine has came from and, perhaps where it may lead, but it is not for the faint hearted.

Gavin Young

Seeds of Mortality: the public and private worlds of cancer
Stewart Justman
Ivan R Dee, 2003
HB, 224 pp, £18.95, 1 56663 498 9

Writing my way through cancer
Myra Schneider
Jessica Kingsley, 2003
PB, 208 pp, £14.95, 1 84310 113 0

The Writing Cure: how expressive writing promotes health and well-being
Stephen J Lepore, Joshua M Smyth, (eds)
American Psychological Association Books, 2002
HB, 304 pp, £21.91, 1 55798 910 9

BEING ill is not a passive project in our culture. We expect to know about our diseases and disorders, to know quite a lot about self-help and complementary medicine, and to do something with that knowledge. This might include belonging to a self-help group, talking to friends or a therapist about the disorder, or even going more public than these small groups. The 'doing something' might increasingly involve writing. Two of these books offer help and research data about writing about illness, whether physical or psychological. The other is a plea for silence and lack of publicity.

Being ill, or having suffered trauma, can cause stress, anxiety and depression. Illness can disrupt or destroy hopes and life expectations, as well as bring pain, disability, and fear of pain, death, and loss. If these are not expressed and explored, the stress, anxiety or depression can worsen the illness experience in a variety of ways. Talking about such subjects can be painful, difficult, and, for some people, impossible. It not only takes time to talk such areas through, but also the availability of the right supportive listening ear for long enough, and courage to utter the words. Writing can be done in the sick person's own time and at their own pace; the initial listener is the writer themselves. Less courage is needed to confide in the privacy of a piece of paper; writing down such material can take less time than saying it. When the writer has gained strength from the semi-openness of bringing their thoughts and fears out onto the page, they can be far braver in sharing such issues with a significant other.

Myra Schneider's book contains excerpts from her journal, her simple and straightforward poetry about her experience of cancer, and advice on how to begin to write, often using imagery. The poetry uses a great deal of imagery, such as snowdrops standing for bravery and purity against the harsh cold damaging world. Myra, an established poet and author of a handbook on writing for personal development, clearly found her writing enormously supportive throughout the cancer experience. She clearly and simply offers exercises and routes to self-expression and exploration. I particularly like her 'dumping' exercise: listing all the things that cause fear, anxiety or hurt at any one time. Her poem about anger, starting in this way, is powerful, funny, and clearly therapeutic, both to reader and writer.

The Writing Cure is a tome, clearly, simply and energetically offering research data (mostly randomised controlled trials) on therapeutic writing, and 'exciting and original ways in which writing is being implemented in clinical practice' (page 12). It points out what I have previously said in these pages, that writing is such a powerful therapeutic method, that if drugs companies could market it in a pill, everyone would be exhorted to use it all the time.

Stewart Justman writes about his own cancer. But his message paradoxically is that some of the old ways of dealing with cancer — in private — are better. He questions the usefulness of self-help groups and being open about being a victim of the disease. I think he has a point, in that quietly getting on with life (or dying) and treatment cannot happen now. It is certainly very difficult now not to know one has cancer. I think my mother would have preferred not to have everyone know and talk about it. I think she would have preferred not to know she had cancer, to do without the oncological treatment too, and just quietly have died of 'old age'. But sadly, despite the interesting and arresting message, I don't recommend you to brave Justman's muddled prose and complex use of literary and artistic examples.

These writers are taking responsibility for illness, or encouraging others to do so. There are powerful strategies here for dealing with illness and trauma.

Gillie Bolton

Longest serving NHS computer program?

In my loft yesterday I came across some dusty black cards. A few readers might actually have seen them as a poster display on the Isle of Wight in 1986 at the annual conference of the British Diabetic Association (as Diabetes UK was then known). The banner read *MicroDM: Diabetic Clinic Microcomputer Program*. I wrote the program in 1983 on a BBC computer to help coordinate diabetic care between local GPs and the hospital clinic. Some patients attended the hospital only a week after a full work up at their GP surgery, while others missed out in both primary and secondary care.

Clinical details of all the diabetic patients attending Luton and Dunstable Hospital were held on two floppy discs — and they really were floppy. What struck me is that the program is still in daily use. Admittedly it is version 13, but it is still the same program running on an Acorn, a British computer sadly no longer in production. Apart from the occasional transplant surgery for the memory, it runs fine, providing and receiving information to and from both the hospital department and GPs. Thanks go to Basil Harrold, who had the foresight at the start to trust his registrar wasn't wasting money and time, Jill Fenwick who has given it daily rations of information, and Richard Ball who provides it with a weekly vitamin supplement of HbA_{1c} results on a (modern non-floppy) floppy disc.

The program is to take a well-earned retirement soon, but sadly it will be replaced by a commercially produced program, which may serve the hospital well, but ignores what goes on in primary care. Progress ... ?

Can any reader nominate a program that has been serving the NHS longer?

Ian Hill-Smith

Abode of Peace

MID-WINTER and the rain thumps the concrete in the courtyard. Outside the practice reception I spy a mother fighting with tangled toddler, umbrella and combative pushchair. I feel the momentary illusion of England, the crisp bite of frost and imagine stepping out to help the mother, frozen sausage-fingers and candyfloss breath. But this is Brunei, a steamy jungle-fringed strip on the north-west coast of Borneo. Here the rain comes with warm monsoon enthusiasm. The only chill is from the air-con, its thrum the tinnitus of expats.

A British protectorate in the 19th century, the British Army has been in Brunei since the 1860s when we were cordially invited by the Sultan to pop in for tea and scones. We generously helped to shoo off some rebellious types keen to foment trouble and the ‘Abode of Peace’ has quietly continued to pull up vast quantities of oil ensuring a cosseted existence for both its ruler and people. The British contingent here is largely Gurkhas with their families and so the majority of our patients are Nepalese.

I try not to dwell on the consultation sins, so carefully expunged as a registrar, that I now commit on a daily basis. I confess freely that I have abandoned open questions. The language skills of the soldiers are generally excellent, but English is not their tongue and the subtleties of the consultation are lost when using interpreters. My style has become clipped and ultra-direct. My standard spiels are littered with dodgy Nepali and have been condensed into pidgin English packages for culturally appropriate consumption. I am morphing into a starchy patriarch with sinister colonial overtones. So, I do penance when the Brits come in and I revert to rabid registrar inflicting MRCGP video-style deconstruction. They stagger out muttering about the games doctors play.

It is essentially a British general practice with plenty of minor illness and our fair Army share of sporting injuries. Chronic disease is minimal but the interface with secondary care is a constant source of bewilderment. We receive no paperwork and reply on verbal messages passed via patients. None of this is conducted in the first language of the patients and so on occasions it resembles a gruesome Kafkaesque version of the parlour game, Chinese Whispers. Throw in some TB, scrub typhus, dengue and some really exotic dermatology to complete the clinical picture.

Bites are a fact of life in this part of the world. We see patients with bites from dogs, snakes, centipedes, scorpions, monkeys and the ubiquitous mosquito. Even swarms of bees have been a problem. Admittedly not in my clinic, but as a personal experience, and so, that much more unpleasant as not experienced by proxy. The wife and I were enjoying the serenity of a quiet Christmas stroll on a local jungle trail; there were birds chattering in the trees, a shady path in a tropical idyll with nary a tourist in sight.

Next minute, the monkeys are shrieking and the birds have taken flight. A swarm of oversized bees (it could have been hornets, entomology is not my strong suit) descended and literally got stuck in. The shrieking monkeys were of the *Homo sapien* persuasion and any other simians in the vicinity were keeping their heads down. The wife showed an impressive turn of pace and set off for civilisation, divesting herself of personal possessions as she went. The honey-monsters were not going to give up easily and I whirled my towel around my head, wielding it with Highland ferocity as we headed for the sea. The wife begged for a rest but pleas of impending vomiting fell on deaf ears. (I had a bee lodged in the right meatus to distract me). We threw ourselves into the ocean to drown the tenacious hangers-on. I lurched over to the nearby Ranger station and reported the danger to the authorities. Bemused would be a fair description of them, but they sportingly picked out several stings from the more inaccessible parts of my body.

I sit in my surgery idly scratching at my swollen bites. It is a unique situation; Brits giving primary care to Hindis in an Islamic sultanate with a Malay culture. Our practice staff are largely Chinese migrant workers and at home we employ a Philipino *amah*. A truly transcultural experience; even Qureshi might blink. A British model of general practice, complete with clinical governance and its baubles, thriving in deepest darkest Borneo.

Euan M Lawson

GPR Idol

NEVER forget that training registrars in general practice is fun. To prove the point I’m developing a board game called *GPR Idol*, although I haven’t decided on the spelling of the second word yet.

On the box lid is the beaming backlit face of training guru Roger Neighbour. If you look closely it’s really a silvery hologram and moving your head from left to right it transforms into an image of Michael Balint. Inside is your very own GPR video kit, complete with an antique camcorder two generations behind the latest digital models. For that essential just-off-perpendicular look favoured by most registrars the camera comes with a stylish base of three dog-eared *MIMS* and a piece of folded cardboard. For doctors who find it tricky to frame the video image, the camera viewfinder has a handy red box painted in the bottom-left sixteenth of the screen to indicate where most registrars position their consultation.

I've developed games to take the tedium out of watching the resulting videos. A favourite is *Consultation Lingo-Bingo*. Each player has a scorecard that contains a grid of words. For example you might have: ideas, concerns, expectations, feelings, thoughts, amoxicillin. The aim is to mark off each word as it comes up in the video. The first player to complete a line shouts out 'PENDLETON!!' and is deemed to be the winner.

The most difficult game is *Euphemism!* Your registrar plays one of their tapes and you have to feed back to them that their videoed consultation is awful — and here's the tricky bit — without using the words 'rubbish', 'codswallop' or 'but'. Don't worry if you get stuck: simply choose a 'handy-hint' card and see how the pros would do it. Examples include:

The positive: 'Good — a video with lots of learning points.'
The reflective: 'I'm just wondering how you might have done it differently.'
The Noel Coward: 'Of course, dear boy, your commitment to a registrar year in general practice doesn't necessarily mean you should abandon your aspirations in orthopaedic surgery …'

And the ever-popular elongated affirmative:

The Paxman: 'Yeahhrrss!!'

There's something for everyone in *GPR Idol*. Novices will enjoy the trainer starter-pack. A set of scrabble tiles provide hours of fun as you try to form — in the right order — the acronym for that Joint Committee of something or other that regulates GP training: JCTPGP, JPCTG, JC … oh, it's a hoot. And notice that mirror. It's there to help you hone that trainer look. Learn to bring your palms together and then touch your nose with both forefingers. Screw up your eyebrows and nod slowly. You can say any old rubbish while adopting this pose and it sounds like ancient Zen wisdom. Try it!

'… ahh, child as presenting complaint…' *Nod* 'yesss …'
'… the angry patient …' *Nod* 'makes you feel angry ...'
'… *silence* … good …'

As an introductory offer I'll throw in a copy of the 2004 Munno's *Miscellany of Trainer Phraseology*. Here's a preview of this year's top entries:

- And how does that make you feel?
- I'm not here to give you the answers; I'm here to help you find them out.
- Have you started your audit?
- We'd be doing you no favours if we allowed you to consult at 20-minute intervals for too long …
- It's important for your educational and professional development that you pitch in with extra appointments/extra visits/flu clinic/repeat prescriptions …
- Umm, that's a good question — tell me why you ask? (see point 2)
- Have you started your audit? (see point 3 — can't be said too often)
- But ask yourself why did the patient actually come in today? (This is a great multi-purpose sentence: say it over and over and see how shifting the emphasis from word to word gives you a whole hour's tutorial.)

The *Miscellany* is packed full of ideas. Planning a tutorial need never be a chore again! Appendix A outlines just how easy this process can be. It shows you how with just two words you can structure any learning experience. Take *agenda*: patient's agenda, doctor's agenda, learner's agenda, teacher's agenda, ethical agenda, political agenda, hidden agenda, society's agenda, agenda agenda agenda — get the idea? The other word is any that begins with the sound *wh*: why, who, what, when, where. All you have to do in any tutorial situation is, every 10 minutes or so, randomly pick one *agenda* word and one *wh* word and make them into a question. Let me demonstrate:

11:00: Cup of tea. GPR shows video.
11:10: 'So, Tim, that's very interesting but what would you say was the patient's agenda here?'
11:20: 'Great, very good — tell me, where is the ethical agenda?'
11:30: 'Okay, who exactly has a say in shaping society's agenda?'
11:40: 'Uh huh, and how does that make you feel …'
11:50: '... and, by the way, have you started your audit yet?'
12:00: Close. Cup of tea

Easy, isn't it?

Antonio Munno

The influence of the tricorder

My medical education comes from a fairly broad base. Much of my undergraduate gynaecology was gleaned from the pages of that august journal, *Cosmopolitan*.

Still, the medical education of my patients draws on sources just as wide. Although widely cited, 'Aunt Millie', 'Mrs. Pettigrew from No. 54', and 'Audrey from Accounts' (and I hesitate to call them Old Wives) may not have the most pervasive influence. That may not even be the responsibility of *Casualty*. No, I think most people believe we practice medicine like they do on *Star Trek*.

It's not explicit. I've not had anyone asking for a re-alignment of their dilithium crystal phase shift plasma generator processors, (although perhaps that's just because they know how long the waiting list is). What I have been asked was 'Could you refer me to hospital for a general check up and lots of tests?'

What he really wanted was the tricorder. For those of you who don't admit to being Trekkies, this was the black plastic box that Dr McCoy would wave over anyone looking a little peaky. It would sing 'wheeoyou', which served as history, examination and a battery of investigations. This invariable sound would tell McCoy, (a grouchy old character, who I never saw ask anyone about their ideas, concerns or expectations) that the patient was suffering from a never-before-encountered virus that robbed earthlings of their humility and covered them in spots. The search was on for a cure.

The tricorder gives absolute answers, absolutely correctly. There are no false positives or false negatives. And this is what our patients want from the technological wizardry we claim to offer them. It's what we want, as well, really, but the mechanics of sensitivity, specificity and normal distributions of continuous variables don't allow it. I tried explaining to my patient that tests can have false positive or negative results and we would probably not be any further on with what was wrong with him, although we'd both be more anxious. Furthermore, 5% of the population by definition will have an abnormal blood result and have absolutely nothing wrong with them. All four of our eyes glazed over at this point, and I continued, 'Well, we could try a re-alignment of your dilithium crystal phase shift plasma generator processors.' I have to get better at explaining this.

While I think up better explanations, though, I imagine a *Star Trek* episode that would make my life easier. (It would probably be *The Next Generation*, as Dr Crusher is much more touchy-feely and may even have read *The Inner Consultation*.) The tricorder, being the all-encompassing diagnostic tool that it is, has undergone extensive trials against a gold standard in every known disease (no mean feat for a never-before-encountered virus). For each 'wheeoyou,' an additional 'wheep' at the end tells Dr Crusher the positive and negative likelihood ratio for that diagnosis with 95% confidence intervals in brackets. As well as diagnosing never-before-encountered viruses, plasma radiation sicknesses from all galaxies and alien mind-swaps undetectable by any other means, it will even diagnose those extraordinarily rare conditions on the Starship Enterprise, gastroenteritis, migraines and depression. What an advanced civilisation!

There is only one modification necessary now. For those times when a red-tunicked crew member gets hit on the head by a polystyrene asteroid, why not get the machine to put in the sutures. Or, as Captain Jean-Luc Picard would say: 'Make it sew.'

Tim Senior

UK Council: February 2004

Shipman Inquiry
A number of Council members spoke in what proved to be a lively debate on issues arising from the Shipman Inquiry seminars. I would urge all Members to read the excellent summaries of the seminar transcripts produced by the Information Services team which will be available on the RCGP Member's website. As you know the College has produced detailed responses at all stages of the Inquiry, but there is a further opportunity for members to comment on the topics raised in the discussion papers and seminars if they wish to.

Budget 2004-2005
The Honorary Treasurer put forward the draft budget for 2004–2005 recommending a small surplus budget. Following considerable debate it was agreed that the College should increase the full subscription rate for 2004 by a below inflation increase of £6. A revised charging system for payments made by cheque, credit card and quarterly direct debit was also agreed and will be introduced from 1 April 2004.

Motion to Council
Joe Neary presented his motion to Council regarding the consultation period. This initiated an interesting debate and resulted in the revised motion being agreed as follows:

> *'The RCGP affirms the importance of ensuring that the length of consultation meets the needs of the patient. The RCGP further affirms 10 minutes as the normal period required for quality consultation and advocates the greater use of extended consultations for complex health, social or cultural needs'.*

Further work resulting from this statement will be carried out and disseminated to members on completion.

Curriculum review
Professor Steve Field, the Education Network Chairman reported on progress to date and it was agreed that a paper covering both Assessment and Curriculum modules be brought to the next Council meeting in June.

Clinical Governance of GPs with Special Clinical Interests
Council was unanimous in its agreement that the RCGP should engage with the development and quality assurance of individual GPwSIs and GPwSI services to ensure that a system for coherent national accreditation standard is developed.

Major Incidents and Disasters — the role of the GP and the primary health care team
This was approved as a College position paper subject to some minor alterations. This will be published as a College statement and will be disseminated to PCOs and other relevant bodies across the UK.

PMS and GMS contracts and the implications for the College
Council received the papers produced by Drs Tony Downes and Philip Evans outlining the implications of both PMS and GMS contracts. This is an issue of major relevance to all members and if you have any further comments on issues that you feel should be addressed please email them to the Chairman at **dhaslam@rcgp.org.uk**.

If you would like any further information on matters discussed at Council please contact me by email at **honsec@rcgp.org.uk**.

The next meeting of Council will take place on 19 June at Princes Gate.

Maureen Baker

The RCGP's new Chair elect

Dr Mayur Lakhani FRCGP is to become next Chairman of the RCGP and will take over from the current Chairman, Professor David Haslam, in November 2004. Elected by the RCGP Council, Mayur Lakhani has a long involvement with the College and held the post of Vice-Chair from 1999–2002.

Dr Lakhani has been a GP principal since 1991 in Sileby near Loughborough. The practice has won several awards for quality. An active member of his local Professional Executive Committee, Dr Lakhani is particularly interested in clinical governance and commissioning of services. He is also a GP appraiser.

In 2000 he was appointed editor of *Quality in Primary Care*; a quarterly peer-reviewed journal which is the first European journal devoted to quality in primary care. Dr Lakhani has also published extensively in the areas of quality and health service policy.

As Chairman elect, Dr Lakhani says he is keen to ensure a smooth transition by working closely with current Chairman David Haslam before he takes over in November:

> *'I am delighted to have been appointed Chairman elect. This is an enormous privilege. As a front line GP, I am well aware of the key issues facing general practice. I am optimistic about the future: I believe that the best days for general practice are ahead of us.'*

john sanders

MEMBERS who have occasion to use the dining room at Princes Gate will know that the College Grace is written on a wall plaque near the serving hatch, together with an acknowledgement of the composer who set it to music. Dr John Sanders OBE, who died on 23 December 2003, was one of the most distinguished cathedral organists of the second half of the 20th century, and a very good friend of the College. Driven by a strong sense of vocation himself, he was drawn naturally to doctors, among whom were many of his closest friends.

The 1998 Spring Meeting was to be held in Cheltenham. John readily agreed to set the College Grace for the occasion provided it was translated into Latin. Our committee accepted this condition and was rewarded with a beautiful setting for SATB that John dedicated to the Royal College of General Practitioners. He insisted that the copyright be vested in the College and would not accept a fee. His known interest in fine claret did lead, however, to an appropriate gesture by the College committee!

His setting was first performed at the formal dinner in the Parliament Room at Gloucester Cathedral. John himself conducted, one of us sang and the other presided. He had already started the evening with an organ recital in the Cathedral and he had had to rearrange the Grace in a lower key for a five-part male choir, who were to give the second performance the next evening in Cheltenham Town Hall.

In addition to helping the College he gave many recitals and talks to the BMA, associated organisations and medical charities. His great distinction was so lightly worn that it never concealed the essential man of modesty, humanity and warmth, who would have loved, himself, to be a doctor.

John Bennett
Brian Cookson

diary

neville goodman

Diminishing targets

FIRST, I'd like to say thank you to John Reid for taking the first step back from targets. He is not yet fully able to admit that they caused more problems than they solved, but he is still in government. Contrition on that scale will have to wait for his memoirs. Some years ago, after introducing an earlier upheaval, Kenneth Clarke was asked if he had really thought that his reorganisation would improve the NHS. That wasn't the point, he replied. The point was to introduce change; what effect it had was irrelevant.

Doctors find it very difficult to live with this. We are appointed as consultants or general practitioners, fully expecting to spend 20 years or more in the same post. Senior doctors move between posts more than they did, but a lifetime's work in one hospital or surgery is still the norm. While there is the danger of ossification, it does allow a long-term outlook and a good understanding of how the NHS works on a local level. Politicians on their 5–year cycles and managers who move every 3 years have to be seen to have done something, or are judged failures. So we live in a world of permanent short-cycle change, driven by people who don't know how the NHS works, and knowing we will have to sort out the mess when the politicians and managers move on. Except that we never can, because the next group of politicians and managers have already moved in.

The end of targets has been signalled, but we are still having to live with them. Patients appear on operating lists with the word 'breach' in brackets after their names. This means that the patient is about to become a '12–month waiter', and there is nothing worse than that. Managers scurry around moving these patients between lists desperate to get them operated on. It throws up all the nonsenses you could predict — patients discharged earlier than perhaps they should be to release beds, non-urgent operations taking precedence over more urgent ones, patients brought into hospital who turn out not to need their operations or to be unfit for them.

The *Tomlinson Report* has just condemned the present school exam system of GCSE, AS and A levels. We are to have a new graduated diploma. Will this be real improvement, or is it just another political cycle? The more one sees of political fiddling with complex systems, the more cynical one becomes. Constant upending of the compost bin to see what was in the bottom layer seems the way the garden works. Which is fine if the flowers bloom.

our contributors

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emyr gravell

How to save your marriage

THE institution of marriage seems to be under threat and many people question its place and relevance in the modern world. Divorce rates are rising, marriages break up quicker and many young people are choosing to live together rather than commit themselves to a partnership for life. Surveys show that public confidence and trust in the institution is still relatively high, but I think that radical modernisation is needed to prevent further decline in marriage's public image.

Currently, once a couple have registered their marriage vows, there are no checks to ensure they maintain good marriage practice. This is no longer acceptable in today's society with its emphasis on openness and accountability and a process that allows couples to regularly demonstrate their fitness to continue their marriage is long overdue. I propose that this process could be based on the General Marriage Council's document *What Makes a Good Marriage* and would have two components — Continuing Marriage Education or Continuing Pronuptial Development (CPD) and the development of a new General Married State Contract that will focus on rewarding quality in cohabiting behaviour.

For CPD, couples will have to demonstrate a log of activities that ensure they are aware of current best practice and they will have to prove that their cohabiting behaviour is up to date, evidence-based and effective. They will also be expected to show evidence of reflective thinking on the quality of their married life, identify areas where their marriage needs to be strengthened and produced a plan — a learning portfolio — of how they intend to address those areas in the coming year. This will not be a mechanical box-ticking exercise, but will aim to foster a culture of lifelong learning among couples.

The new General Married State Contract will have a quality framework, which will enable couples to demonstrate evidence of cohabiting excellence. Senior members of the British Marriage Association, respected for their knowledge and experience (many of them in their third or fourth marriage), have agreed on key areas that identify high quality relationships.

Points awarded for various indicators in these key areas will give an objective, mathematical score of the quality of a relationship. These indicators have not been fully developed yet, but possible ones are:

- Communication — Points will be awarded for keeping a register of every important conversation, discussion and argument. The total number of words spoken in a set monitoring period as compared to a national average will also give an objective guide to the quality of a couple's communication and points will be awarded accordingly. The contract will allow exemption reporting in this area. For example a communication issue may be deemed inappropriate for intensive monitoring if it is long standing and has shown no sign of resolving despite regular efforts at communication for many years. Examples might be fruitless discussions about unfinished DIY projects or long-standing grievances of the 'you never say I look nice anymore' variety.

- Sexual practices — Points will be awarded here for the amount of sexual activity and for the quality of that activity. It is expected that recent improvements in IT will be able to measure the number and intensity of orgasms and detect any fake orgasms (currently only male version available). These indicators will obviously have a seniority weighting. The formula will be based on complex regression analysis of decline of sexual activity with years and also take into account well recognised indices of deprivation affecting sexual prowess, such as a public school education or still reading Harry Potter books as an adult.

Points will also be awarded for objective external evidence of quality in the marriage from questionnaires filled in by family, friends or neighbours. Other key areas will include the state of a couple's finances and the behaviour of their children.

To help couples focus on these priority areas the contract will allow them to opt out of 24-hour responsibility for married life. Couples would no longer have to deal with problems arising outside normal working hours or on weekends and Bank Holidays. Out of hours emergencies, such as dealing with vomiting children in the middle of the night, picking up teenagers from a late disco or visiting aged relatives on Bank Holidays, will become the responsibility of the local Partnership Care Organisation.

This contract will not only improve the lives of existing married couples, but also provide an incentive for previously wary couples to commit themselves to marriage. It will guarantee an institution that is robust and appropriate for the 21st century and usher in a new golden era for marriage.