33rd Annual Scientific Meeting of the Society for Academic Prim

RUNNING through an exciting fabric of high quality scientific and educational presentations was the thread of research governance. It is clear that the time, effort and bureaucracy required to meet the exacting standards are becoming ever greater. It is a matter of time before these outweigh the potential benefits of new planned research. One team had to obtain formal approval from 59 research management and governance organisations to conduct a straightforward postal survey — a process that took 5 months and was still not completely successful. While no researcher doubts the value of research governance, at this conference there was a clear need expressed to streamline the process. This could begin by the agreement between the organisations involved of common standards and approaches, and a widespread commitment to the avoidance of duplication. Otherwise, primary care research, whose growing health was demonstrated in Glasgow, is under serious threat.

Blair Smith

THE sentiments of the internationale could be detected at the 2004 SAPC conference on Clydeside in 2004 as research and teaching staff responded to the call 'arise ye from your slumbers'. The meeting provided further evidence that academic general practice has started to move out of established national boundaries with collaborations like the Brisbane Initiative to encourage research training in different countries recently. There were overseas speakers, representatives from the North American Primary Care group (NAPCRG) and editors from our major journals like the *BJGP*, *Family Practice* and the *Annals of Family Practice*. Two of the best presentations were selected, and funded, to represent general practice in the UK at the combined NAPCRG/WONCA conference in Orlando in October 2004. When SAPC next convene during July 2005 in Newcastle/Gateshead the reciprocal transatlantic crossing will be made by their best presenters. We may yet have to wait a few years before academic general practice 'unites the human race', but SAPC in Glasgow made an excellent contribution to the process.

Frank Sullivan

AN unusualy large number stayed for the last morning, which was enlivened by a series of special sessions, beginning with John Hutton, Minister of State for Health, standing in for John Reid at the last minute and giving a very helpful address on the policy perspective on the future of primary care. Mr Hutton was unusual, not only in staying for questions, but also by responding to challenging questions with the comment that this was a group he needed more contact with. So plans are already afoot for a meeting with the Minister, to discuss research-based inputs to government policy for primary care. Not a bad result, as these things go.

There followed a poster session, fulfiling the organiser's promise that every poster would be subject to peer review and comment. Feedback suggests that this was a popular session, which over-ran in several cases, due to shared interest in research in over a dozen topic areas.

After a fifth parallel session of scientific presentations, the final session of the conference covered many issues in quickfire succession — bottles of Bollinger for the conference team, a quick debrief on the Minister's visit, the award of two bursaries for the best presentations to be given again at the next meeting of NAPCRAG in Orlando, an enticing presentation for next year's ASM in Gateshead and a standing ovation for Roger Jones' contributions to academic primary care.

The College has launched the **Paul Freeling Award** (PFA) for innovative or meritorious work in the field of vocational training in general practice.

The Award, open to course organisers and trainers, is inspired by the work of the late Professor Paul Freeling. Award winners will receive a certificate and £1000, donated by the Professor Freeling's widow, Mrs Shirley Freeling. The Award's presentation will take place annually.

Application for the PFA is by nomination or self-nomination; using the application form available on the RCGP website. All entries must be received by 15 September 2004. Applications for the Award must be made on the application form available on the RCGP website.

For more information on this award and for an application form visit the RCGP website at:
http://www.rcgp.org.uk/corporate/awards/paulfreeling.asp

The conference closed with a rapid presentation of 100 photographic images, producing rapt recognition of the people, places and activities of the conference, played to the resounding soundtrack of Local Hero — appropriate not only for its title 'Going Home' but also the efforts of a large team of local heroes, who had worked hard and long to ensure a memorable visit to Glasgow for their guests to the city.

Graham Watt

As an SAPC neophyte I was struck by two things. Firstly by the immediate relevance of primary care research to everyday primary care. This is not always obvious to sceptical non-academe, and even *Doctor* columnists would have relished presentations like Chris Dowrick's, on medically unexplained symptoms, or Jacques Mizan, on the effects of the built environment on doctor–patient interaction (see October 2004 *BJGP*). There were many other excellent presentations during the parallel sessions where the chief challenge as always was to choose one presentation from such an extensive menu. Two excellent plenary speakers also spoke directly to every GP in the land — Martin Roland from Manchester on the research base for the quality component of the new GMS contract; and Glasgow's David Reilly, stimulating as always, on the power of placebo, prickly when defending RCTs in homoeopathy, and astonishing when soaring in new realms such as psychoneuroimmunology.

And the second thing? There is much at SAPC for the amateur independent researcher curious to learn more. But costs are prohibitive without subsidy from large academic departments. Any chance of a discount at Gateshead?

Alec Logan

mike fitzpatrick

Should we welcome the end of the sick note?

I don't recall the exact moment when I realised that the sick note system was doomed. But I do remember the time before the 1992 general election when patients started to turn up asking to be certified as unfit for work on medical grounds, indicating that they had been sent by the local benefits agency where they were currently registered as unemployed. Unemployment was then still a sensitive political issue, and the government, already notorious for its manipulation of the jobless figures, had discovered that the unemployment rate could be reduced still further if more of those out of work could be redefined as sick. A few months later, the election won, and another government department found itself struggling with the mounting cost of paying out long-term benefits to this cynically created army of invalids. Some of the same patients were sent back, now under pressure to be certified as fit for work.

This experience of the subordination of medical authority to political expediency, so typical of relations between doctors and government in recent years, marked the beginning of the end of medical certification of sickness absence. Over the past decade, there has been an apparently uncontrollable rise in the numbers claiming sickness and invalidity benefits, and in the numbers taking early retirement on medical grounds. The common feature of a series of initiatives by benefits agencies and employers is the removal of GPs' traditional role in certifying incapacity. Although this trend is generally welcomed by GPs, it is symptomatic of changes in the relationships between the medical profession and the state, on the one hand, and between doctors and patients, on the other, that threaten to undermine doctors' therapeutic potential.

The role of doctors as gatekeepers to the benefits system was inaugurated by Lloyd George's 1911 National Insurance Act and consolidated in Beveridge's post-war welfare state. The medical profession's commitment to public service was expressed in its robust promotion of the values of hard work and civic duty and its ruthless dedication to the detection and punishment of the malingerer. The end of full employment and the decline of civic virtues and moral consensus have undermined all these values. Furthermore, the pursuit of an agenda of relentless marketisation by the governments of the past 20 years has fostered a 'culture of distrust' with a corrosive effect on all forms of professionalism and public service.[1] The medical profession, in particular, has been disparaged as self-serving, elitist and paternalistic, its expertise questioned and its authority reduced.

Meanwhile, the inflation of health to become a major preoccupation of national and individual life has led to the inexorable expansion of the sick role. The dramatic increase in incapacity for work is largely attributable to musculoskeletal and mental health problems, and to 'subjective health complaints'.[2] Although 'it is difficult to adduce a biological explanation' for the modern epidemics of low back pain, fibromyalgia and repetitive strain injury, for work-related stress and chronic fatigue, which take place in the context of objective improvements in population health, these disorders have been sanctioned by medical authorities, by employers and by government.[3] Some have questioned doctors' 'misplaced compassion' in medicalising 'illness deception and malingering', pointing to the resulting 'deterministic devaluation of personal responsibility'.[4] As Peter Halligan and colleagues put it, 'to confound a medical disorder with social deviance serves neither medicine nor society and ends up by denying one of the most fundamental characteristics of human nature'.[4]

However, most doctors, confronted with the difficulties of distinguishing feigned and real illness behaviour and with the demands of patients backed by forceful advocacy groups, have long abandoned any attempt to contain the surge of subjectively-determined incapacity.

Many GPs express relief at the prospect of the lifting of the burden of policing the benefits system. But the medical profession's loss of the role of gatekeeper reflects a wider loss of authority that is crucial to the therapeutic relationship between doctor and patient. Contrary to the notions of vulgar critics of paternalism, a division of labour between doctor and patient, in which the patient submits to medical expertise and authority, is crucial to the treatment of illness and the alleviation of suffering. This is confirmed by the familiar intractability of subjective health complaints to any form of medical intervention. The price of being relieved from policing our patients may be that our capacity to doctor them is also diminished.

References

1. Marquand D. *Decline of the Public.* Cambridge: Polity Press, 2004.
2. Aylward M. Origins, practice and limitations of disability assessment medicine. In: Halligan PW, Bass C, Oakley DA (eds). *Malingering and illness deception.* Oxford: Oxford University Press, 2003.
3. Wainwright D, Calnan M. *Work stress: the making of a modern epidemic.* Buckingham: Open University Press, 2002.
4. Halligan PW, Bass C, Oakley DA. Wilful deception as illness behaviour. In: Halligan PW, Bass C, Oakley DA (eds). *Malingering and illness deception.* Oxford: Oxford University Press, 2003.