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.