

of the general public.

The European Working Time Directive has reduced doctors' hours — yet we are reliably informed that the excessive hours of yesteryear were very detrimental to our health and provided poor quality learning environments — so I guess we learnt little from those experiences. The modern system should be better as the doctors are wide awake and enthusiastic, rather than drained, stressed, and exhausted as we were.

Am I the only doctor who thinks that general practice is maybe a bit easier? Since we qualified the BNF has been introduced in its present excellent form, there are amazing numbers of experts who tell us what to do. There are mountains of guidelines and of course, QOF. Evidence-based practice has come into being, and opinion rightly takes second place to evidence. Within seconds you can get reliable information from your computer — even during a consultation. The patients present in much the same way, with much the same problems, and are often easier because they are better informed.

Modern medical education has mushroomed into ever-increasing activity. There are plethoras of diplomas and courses about teaching. So why can it not deliver in 3 years? Is there good evidence that new educational systems are that much better than the old? Is it possible that modern education actually dis-empowers young doctors, rather than empowering them?

When I was a course organiser and trainer, it seemed that there were some doctors who need extra time and help, the great majority who managed quite well, and a very few who should not have got as far as they did. The vast majority do not need an extra 2 years of training. Can the NHS afford it? (Especially if we factor in increased consultation times which the College is championing). Are we moving toward a system of consultant GPs — maybe with lists of 5000, with most work being done by lesser qualified individuals? Does this increasing cost of GPs herald the demise of personal doctoring, long-term relationships, and actually lead us right into Darzi polyclinic general practice?

There is a well known phrase 'the map is not the territory', to which we should maybe add 'theory is not reality'!

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## Knowledge of risk factors in cancer

Many modifiable risk factors for cancer have been reported, including: smoking, estimated to cause one-third of UK cancers;<sup>1</sup> obesity; low intake of fruit and vegetables, and physical inactivity, estimated to cause approximately 3% and 2% of cancers respectively;<sup>2</sup> excessive alcohol use, accounting for about 4% of cancers, and excess exposure to sunlight. Public knowledge of these risk factors is little known, as surveys have generally concentrated on specific cancers;<sup>3,4</sup> or been relatively small.

We performed a survey in eight general practices in Northern England. Adult patients attending in December 2007 or

January 2008 were asked to select six from 12 possible risk factors. As well as the six risk factors, we included six false ones: 1556 questionnaires were returned. The mean number of risk factors selected was 5.6. Results are shown in Table 1.

The virtue of this survey is its simplicity and its size. These are weaknesses too: in that we chose not to request details such as sex or age. However, little difference between the sexes was identified before.<sup>4</sup> In a previous survey of 1000 women enquiring about risk factors for breast cancer two-thirds identified a positive family history, yet only 14% identified age, 19% hormone replacement therapy, and 12% oral contraception.<sup>3</sup> An older survey asked about 10 true and four false causes, similar to this current survey.<sup>4</sup> Smoking results were similar, with 93% identifying a relationship between smoking and lung cancer; likewise, 42% linked a diet low in fruit and vegetables with bowel cancer. Responses for obesity were much lower, with 46% of females linking this with breast cancer, yet only 13% of males doing so: this compares with 70% identifying overweight in the current survey.

Our results suggest publicity about smoking has worked. Similarly, excess sun exposure, excess alcohol use, and being overweight are now generally recognised as risk factors. Less encouraging was the relatively low level of knowledge about diet and exercise. This suggests a new

**Table 1. Participants identifying putative cancer risk factors.**

	Participants marking this factor increases cancer (n = 1556)	
	n	%
Risk factors associated with cancer		
Smoking	1486	96
Exposure to sunlight	1288	83
Being overweight	1082	70
Excessive alcohol	1054	68
Lack of fresh fruit/veg.	654	42
Not taking regular exercise	619	40
Risk factor debatably associated with cancer		
Exposure to traffic fumes	813	52
Risk factor with little or no scientific support		
Exposure to microwaves	554	36
Lack of iron in the blood	487	31
Lack of vitamin C	405	26
Eating spicy food	142	9
Drinking very hot drinks	105	7

direction for cancer prevention campaigns. A significant proportion considered both traffic fumes and microwaves to be risk factors. Although scientific evidence does not support these, both have also had considerable media coverage. How this can be countered is less clear: some of the population distrust much of the information they receive from 'official' sources.<sup>5</sup> Maybe these erroneous cancer beliefs are less important at an individual level — as avoidance of microwaves or traffic fumes is very unlikely to be harmful.

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## Family medicine in China

The paper in this journal<sup>1</sup> made a full description on the past, present, and future of family medicine education and training in China. With regard to the future, the authors suggested that the Chinese National Degree Council should set up an application system of speciality family medicine for Masters Degrees and Doctors Degrees as soon as possible. Currently this

suggestion has been adopted by some leading universities in the field of family medicine education in China, for example, Zhejiang University School of Medicine initiated establishing this in 2008. Students and researchers having Bachelors Degrees in public health and clinical medicine can apply for Masters Degrees in Family Medicine if they are qualified, that is having enough credit hours, publishing academic papers in peer-reviewed journals, and passing an oral examination. Likewise, students and researchers having a Masters Degree in the aforementioned field can apply for a Doctors Degree in Family Medicine if they are qualified in the above aspects. The establishment of this application system is very important for the sustainable development of family medicine in China. The future of family medicine education in China will be very promising.

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## Alford's theoretical work

Charlotte Williamson's piece on Alford's theoretical political model<sup>1</sup> provides a seductive analysis which she is applying to the flux happening now within health service organisation in the UK. However it should be acknowledged that this is a political theory. By describing clinician's interests as 'dominant', the use of language alone implies that their interest should be moderated or brought down.

Alford developed his theory to effect change in 1970s US health care, when many could agree clinician's interests may be entrenched for financial reasons. However, I would argue that what

motivates clinicians who have grown up in, been trained in, and who work in the NHS of the UK is quite different. Williamson alludes to professional monopolists believing altruism as a motivator. I would argue this is a truth rather than a belief. Going the extra mile for the patient, or staying on the extra hour to sort out a problem, demonstrates the beneficence of the clinician and nurtures the relationship for the patient. This is a marker of quality that I have yet to see quantified or put into the equation when it comes to advocating change. It is integral with a sense of ownership of the system by the clinician. Clinicians know it is in the best interests of the patient (and indeed a silent majority of patients know this also).

When clinicians are seen as resistant to change it needs to be borne in mind they are so when they can see a system that works being eroded. The type of personality that is attracted to medicine is not the same as the businessman. When describing our interest as 'dominant', it is not the money that it is making us resist change, it is the preservation of a system whereby we can feel good about doing good. Individual patients see the benefit of this every day. Politicians need to understand how fundamental this is to the whole business of doctors treating patients to the satisfaction of all concerned. And when doctors are seen as resisting change, we need to shout loudly that it is not because of conservatism (with which so may find convenient to label us), but because we are and always have been radical advocates of our patients interests.

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