viewpoint
The Shrinking Acute Hospital

Imagine a planning meeting of the board of a large hotel chain enjoying 80% all year round occupancy, a 2% annual rise in bookings, and peaks in demand that result in guests being turned away or sleeping in the foyer. Would the board recommend contraction or expansion of future capacity?

If it were NHS Hotels plc the board would recommend a 30% cut in capacity within the next five to seven years. Demand will be “turned off” and customers accommodated in small guest houses in the community, or recommended to “holiday at home”. Is this scenario credible?

Under the Private Finance Initiative (PFI) acute NHS hospitals are reducing acute bed capacity by 20–40%. The PFI brings capital into the public sector, replacing acute NHS hospitals with ones that will be owned and run by the private sector (consortia of bankers, builders, and service operators) and leased back to the NHS for periods of 30 to 60 years. The snag is that the lease of these hospitals costs more than the NHS can currently afford and so to make ends meet the NHS has to reduce the number of acute beds it will buy.1 The progressive shrinking of acute hospitals is justified by unproved assertions that increased efficiency, trends in day surgery and a radical shift of care to community settings can accomplish the Canute-like task of reversing the relentless rise in demand for their services.

The large projected transfer of acute and post-acute care will be coped with by the present number of general practitioners. Since Britain’s general practitioners are not obviously under-employed, it is unclear how they can accommodate this extra workload without a substantial rise in work-related stress. To the millennial visionaries in the NHS Executive, this appears a minor detail.

With the advent of a new administration has come the inevitable rearrangement of the organizational deckchairs leading to novel combinations of primary care and acute trusts.2 Hard questions relating to the capacity of the acute sector to cope with the present, let alone future, demand have not been asked. Apart from anecdotal evidence reported by the print and electronic media, several hard end points suggest that rising demand in the acute sector is now colliding with a capacity ceiling.

The long decline in acute hospital bed numbers in England ceased in 1994-95 and numbers actually rose by 1% between 1994-95 and 1996-97. Acute throughput has stabilized in the last two years at 54 cases per bed per year.3 In the new PFI hospitals, acute throughput will rise to the mid-eighties by early in the next century. Surgical inpatient discharges fell by 3% in England and Scotland4 in 1996-97; there is no precedent for such a sharp decline. Since just over half are elective discharges, this represents a probable fall of 6% in this category due to the crowding out by the winter rise in emergency admissions and financial constraints on surgeons who have reached their contract targets. Inevitably, as night follows day, this has been followed by the largest rise in waiting lists on record.5 Warning signs that a capacity ceiling has been reached, abetted by a substantial reduction in NHS spending, has not prevented visionary planning for a shrunk acute hospital sector to proceed apace.

It is time that the disciplines of evidence-based medicine were visited upon these untested visions, with a return to informed strategic planning. General practitioners, who will bear the burden of coping with the failures of shrunk acute hospitals should point out that the Emperor of visionary planning has no clothes.

Matthew G Dunnigan, Allyson M Pollock

References

"Why do World Bank adjustment policies, driven by the developed world, continue to tie the poorest people in the world to poverty and ill-health?"
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The Back Pages...
Revitalize your Faculty

A conference was held in the Thames Valley to unite education, research and service improvement and to emphasize the opportunities in primary care.

This conference was originally conceived, in the autumn of 1996, to raise the morale of the apparently downcast professionals working in primary care. Members of the Board felt that the activities and opportunities had not changed so greatly since the optimistic days of the 1980s: the time had come to remember the good things.

The conference had several aims:

- To pull together the activities of all professionals working increasingly closely in primary care, allow them to display and share their activities, and improve mutual awareness.
- To draw together education, research and service development.
- To celebrate the development of an Institute of Health Sciences in Oxford, with the undergraduate and postgraduate general practice departments, public health and the health authority on the same site.
- To get together, have a party, talk to each other — network!

It was decided to hold the conference at the Institute of Health Sciences. The venue was a problem — no room would contain more than 70 people — but we felt it important to gather people at the place we wanted them to grow to love. They should explore the building, see the new teaching suite, visit the electronically-linked library, watch the Postgraduate Education building going up. We had to erect a marquee, and space required that the conference should be resourced within the Faculty area, and targeted only the professionals within the same area. Mailings to practices, College members, practice nurses, community nurses and Trusts resulted in an attendance of almost 300 over the two days.

It is hard to report a conference of such diversity. There was a keynote talk at the start of each of the two days. For the rest of the days there were usually seven parallel sessions at any one time: 20-minute presentations or hour long seminars, 81 presentations in all. Lunch was packed in plastic bags and eaten al fresco so that delegates could get back to the 58 posters, the computer demos and the CD library demos. The place buzzed.

The range of the presentations was vast, and here it is only possible to indicate a few of the areas that were presented. **Education:** higher training, Fellowship by Assessment, modular continuing education, consultation skills for nurses, educating patients, practice nurse development, “lost doctor”, learning sets, medical student education. **Research:** RCTs in practice, evaluating practice nurse clinics, ambulatory blood pressure monitoring, patient-held records, management of acne, secondary prevention of heart disease, genetic counselling. **Service improvement:** cardiac rehabilitation, needs-led primary care, exercise referrals, diabetes clinics, health walks, handling suicide, complementary and traditional medicine, services for adolescents, contraception clinics, guidelines and audit. **Management:** information technology, rationing and ethics, practice nurses, minor illness clinics, primary care commissioning, practice development planning, producing leaflets.

Evaluation was overwhelmingly positive. We received 106 evaluation forms and 106 of the respondents want a similar conference again. The parallel sessions were the most appreciated, as well as the opportunity to meet with rarely seen colleagues. The following are examples of the comments: “Bursting with ideas of arranging education of my practice and colleagues”, “Not frightened of computer searches”, “Will contact the University Department of Primary Health Care”, “Reinvigorated me to try and run nurse-led clinics”, “We'll look at our osteoporosis management”.

In summary, we felt that we had achieved what we set out to do, and it had a very valuable function. People had met, regained their enthusiasm, and many of the barriers between academic units, education departments, and coal-face workers seemed to be reduced. We shall do it again (not too soon!), and would recommend any other Faculty to try the same.

Martin Lawrence
An All-Party Party...

The All-Party Group on Primary Care and Public Health was officially launched in the Terrace Marquee at the House of Commons on Wednesday 11 March 1998. The College has supported the establishment of this group since it was first suggested — why?

All-party groups have been a feature of parliamentary life for many years. Any parliamentarian can set up a group on any topic, but there are some ground rules which must be met. There must be a reasonable number of parliamentarians interested in belonging to the group, and members must be drawn from a spread of the political parties; ideally, both Houses should be represented. Although membership of the group is restricted to parliamentarians, interested outside organizations are invited to attend and contribute to group meetings. The function of such groups is to encourage discussion and debate amongst parliamentarians on the group’s particular interest. Members of interested organizations can make suggestions for topics of discussion, provide background papers, and suggest speakers and contributors. The idea is to allow frank discussion, and to inform and influence debate in parliament itself.

It is perhaps surprising that there has not until now been an all-party group to look at either primary care or public health. Dr Howard Stoate still works as a GP as well as being an MP; he has been the key figure in setting up this group. A Fellow of the College, he has also been an examiner for many years. He is co-chair with Dr Peter Brand (also a Member of the College), a GP on the Isle of Wight, and Lord Hunt of Kings Heath, formally Chief Executive of the NAHAT.

At the first meeting of the group we discussed the Green Paper A Healthier Nation with Tessa Jowell, Minister of State for Health. The second meeting will provide an opportunity to discuss the White Paper on the NHS with her ministerial colleague, Allan Millburn.

Interested outside organizations who have been invited to attend meetings include the College, GMS, the Association for Public Health, the RCN, and many others. It looks as if it will be a lively Forum in which to discuss a whole range of topics relating to the Health Service. It will hopefully inform College Officers and Members of the views and aspirations of these different organizations and of course of parliamentarians themselves. It will also give us an opportunity to put across the College’s views. At a time of continuing change within the NHS it will give us the opportunity to hear what key backbenchers are thinking — and allow us the opportunity to tell them what we are thinking! A senior DoH official was once quoted as saying “dealing with the doctors is even worse than negotiating with the French” — one hopes that the All-Party Group will help change that!

Bill Reith

RCGP ACCOMMODATION CHARGES

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After-hours primary care in a New Zealand town — lessons for the United Kingdom?

One of the advantages of working abroad is exposure to alternative models of care. I have been working in New Plymouth, a coastal town of some fifty thousand people on New Zealand’s North Island. The town also serves a large rural community. Within the region there are three out-of-hours care arrangements which may be of interest to GPs in the United Kingdom.

In New Zealand all primary care, including out-of-hours care, is provided on a fee-for-service basis, with the patient being responsible for the payment of fees. There are government subsidies for low income groups, for children under the age of six, and, importantly, for accident-related visits. A standard adult consultation fee is about $35-40 (€15). Out-of-hours consultation fees attract a premium of up to $15. There may be a strong financial incentive for service provision, in addition to increasing demand for rapid and convenient access to care. This must be set against the New Zealand GPs’ traditional lifestyle, with different expectations of after-hours care from those experienced by many GPs in the United Kingdom. Home visits are performed much less frequently in New Zealand, being reserved for patients living locally and the truly housebound. This reflects GPs’ reluctance to perform visits, and patients’ reluctance to pay the increased fees. The stage is therefore set for clinic-based care.

Description
In New Plymouth the first “accident and medical centre” was set up by a nationwide private company in association with a small number of local GPs and medical specialists. The clinic is open from 0800 until 2200, every day. At night, phone cover is provided from a centre in Auckland, 500 kilometres away. It is staffed largely by full-time medical officers, usually from overseas. The clinic has several consultation rooms and cubicles, and a resuscitation room. There are X-ray facilities, physiotherapy, a plaster room, a pharmacy, a podiatrist, and a dental clinic on-site. There is a weekly fracture clinic. The clinic was established to profit from the usual range of out-of-hours problems and minor injuries. These areas involve a high throughput of patients, and access to paediatric and accident-related government subsidies. The clinic is also increasingly used as a primary care provider by patients who do not have a family doctor in town, or who enjoy the convenience of a no-appointment system. Such patients are welcomed, and encouraged to return.

The establishment of this privately run clinic was seen as a competitive challenge by the majority of the town’s GPs, who feared loss of both income and patients. The response was to set up a rival operation. This clinic offers a similar range of services, with the addition of local phone cover from the doctor responsible for providing night visits. After-hours staffing is provided by shareholding doctors on a rostered basis, who are reimbursed at an hourly rate.
During the day there is a full time medical officer. The clinic is intended to provide acute primary care and minor injury care only. Patients presenting for primary care of a more ongoing nature are encouraged to attend their GP in an effort to preserve continuity of care and, arguably, practice numbers.

Both clinics have become well established in New Plymouth. Tensions exist as a result of competition for out-of-hours business and because the privately run clinic is perceived as poaching patients from conventional practices. There has been a significant rise in the number of patients using the clinics, both within and outside normal hours, although it is very rare for a night visit to be performed. This rise probably reflects the convenience factor, although a minority of patients attend seeking a second opinion. There is a widespread feeling amongst the local GPs that their daytime practice now seems to consist of the more complicated patients, with others self-selecting to the clinics if they perceive themselves to have a more simple problem. There has been a noticeable reduction in the incomes of some GPs, particularly those who work part time.

Many rural hospitals in New Zealand are facing closure or reconfiguration. One such hospital, some fifty miles south of New Plymouth, is the centre for a rather different model of care. The hospital has a well-equipped emergency department, which is staffed around the clock by a mixture of seconded casualty officers from the base hospital and local GPs. The department offers traditional emergency care during the day with the addition of out-of-hours cover for many of the local practices. There is an eight-bed observation ward allowing short or overnight stays, X-ray facilities, and a physiotherapy department.

Discussion

Many of the advantages and disadvantages of running primary care clinics will be familiar to the growing numbers of GPs involved in cooperative schemes in the United Kingdom. The advantages of a reduced after-hours commitment, and the convenience of working from a purpose-built centre, must be offset against issues such as loss of continuity of care, communication, and complex organization. The second of the after-hours clinics above most closely matches current British models of care in its cooperative principles and support of traditional daytime practice.

All of the facilities described offer an impressive range of on-site ancillary services, particularly in the field of accident care. Such services may become a feature of British primary care in the future, particularly if the arguments to establish centralized accident units are seen through to their conclusion. Patients with minor injuries are likely to be reluctant to travel further, and may present to their GPs. Funding for such facilities would be a problem under the National Health Service. In addition, the doctors involved must demonstrate a broad range of skills. Such skills are, however, no different from those required of GP trainees working in emergency departments, and make for rewarding practice.

There have been calls for patients in the United Kingdom to be charged for out-of-hours care. The examples above illustrate some of the problems associated with fee-based care. With financial incentives comes competition and the potential for privatized services entering the system, to the potential detriment of traditional family practice. It is also clear that fees may not be a disincentive for patients seeking care outside of working hours or in convenient settings.

Amalgamation of the functions of community hospitals with out-of-hours care centres may, in the United Kingdom, as it has done in New Zealand, increase the viability of small hospitals at a time when their future is threatened and health services for rural communities are being reduced.

Primary Care in the United Kingdom continues to evolve at a breathtaking pace. The NHS, in its fiftieth year, has much to be proud of, yet it is always wise to remain aware of how other countries tackle the challenges of service provision. The concept of acute, minor injury and after-hours care based in well-equipped centres is an interesting one, with many advantages for both the patient and doctor. The real challenge is the integration of such innovative centres into the comprehensive, traditional family practice that we all seek to retain. This is a matter for further discussion and I hope to have provoked just that.

Ian Higginson

5 Good Reasons For Going To WONCA...

Number Three

In the dying days of the eighteenth century, Dublin was still the second city of the British empire, surpassed only by London in size and importance. Dublin had its own independent parliament. It was a very elegant city with a population of 100,000 people. However, radical thought was in the air as the century drew to a close.

WONCA '98 coincides with the 200th anniversary of the great Irish rebellion of 1798. The conference runs from June 14-18. In 1798 these dates marked a decisive turning point in the rebellion.

Visitors to WONCA will be walking the streets of Dublin at an important juncture in Ireland's history. As part of your extra-curricular activity I would suggest that you purchase an interesting pamphlet entitled "Dublin in 1798 - three illustrated walks". The author takes you on a guided tour through fashionable Georgian Dublin. He lists the homes and haunts of the central characters in the rebellion. Most of the protagonists knew each other and were neighbours, living within a square mile at the centre of Dublin.

Dublin was a crucible of radical thought in 1798. WONCA '98 promises to be revolutionary.

Leonard Condren

Dublin in 1798 - three illustrated walks.
Denis Carroll
South Hill Communications

The British Journal of General Practice, April 1998 1201
the national depression campaign

The National Depression Campaign aims to increase awareness of depression and its symptoms, encouraging those who may be depressed to seek help. The campaign has been allocated a National Day, the 22nd April 1998. During the week 20–25 April 1998 the campaign will be launching a ‘Myths and Misunderstandings about Depression’ cartoon leaflet. If you would like a copy please send your address and a 50p stamp to cover the postage and packaging, to The National Depression Campaign.

The campaign is supported by a wide range of organizations — the Depression Alliance, Manic Depression Fellowship (MDF), The Association for Post Natal Illness, SAD (Seasonal Affective Disorder), The Samaritans, SANE, MIND, MACA (The Mental After Care Association), The Royal College of Psychiatrists, The Mental Health Foundation and Health Education Authority.

The National Depression Campaign is undertaking a number of projects throughout the year. On The National Depression Action Day, 22 April 1998, there will be the first of three ‘Voice Conferences’ in London. Follow-up conferences will be held in Wales and Scotland in May and June.

The conferences are for people with depression, their families, friends and carers. They are designed elicit the views, suggestions and experiences of the guests invited. The aim is to discuss the issues surrounding employment and depression, exploring ideas about how those who have suffered or are suffering with depression can stay in work or return to work. Speakers have been chosen to represent their field and to inspire discussion.

The results of our national survey will be given at our press launch on the National Day. We are looking at a number of issues, such as where people get information on depression, who they think gets depressed and whether they think there is a cure.

In September we will be having three self-help workshops in Birmingham, Manchester and London, and a videotape training aid will be produced.

The campaign will have a presence at trade fairs and conferences throughout the year and will liaise with the All Party Group on depression in Parliament.

For further information please contact: Theresa Cripps
Campaign Coordinator
The National Depression Campaign,
35 Westminster Bridge Road,
London SE17JB

E-mail: tcripps@ndc.k-web.co.uk
Website: http://www.charitynet.org/~ndc
Tel: 0171 207 3293
Fax: 0171 633 0559

the 1998 medical society of london prizes

Resulting from the generous patronage of The Medical Society of London, the Medical Writers Group of the Society of Authors will reward good writing/illustration of medical and dental books by offering £1,000 prizes in the following categories:

Basic (undergraduate, review, atlas) books; Advanced authored books (monographs, postgraduate, specialities); Advanced multi-contributor books: Medical history/general interest books; Asher prize: first textbook by one (maximum two) author(s).

Credit will be given for originality, content, presentation, scholarship, clear and lucid prose; relevance, quality and clarity of illustrations; and the standard of indexing. (For electronic publications: educational structure, ease of ‘navigation’, and attractiveness of interface will also be considered.) The prizes will be awarded to the authors/editors who, in the opinion of the judges, made the greatest contribution to the understanding of a particular field.

ELIGIBILITY
2. Second and subsequent editions of books published between the above dates are eligible provided that they have not previously been submitted for a prize in any category.

SUBMISSION
Entries must be submitted by the publisher(s) (who should indicate into which category they wish their books to be entered): they should send THREE copies of each work, non returnable, (certifying that it is a first textbook, where applicable) to the Medical Writers Group, the Society of Authors, 84 Drayton Gardens, London, SW10 9SB, NOT LATER THAN 30 JUNE 1998.
A short history of socialized medicine... 7

Paupers or Patients? — Social Medicine and the Revolution

The French Revolution in 1789 removed formal medical regulation and institutions, but the requirements of the revolutionary army ended the free-for-all. New medical schools were established in 1793, and Napoleon introduced a national system of licensing in 1802. Similar rapid change occurred within institutions such as the Hotel Dieu, where transition to state management of the medieval Paris poorhouse transferred authority from the religious to the medical profession. Revolutionary thinking allowed doctors to take control of the bodies of patients, who were observed in minute detail in life and death, autopsies facilitating confirmation of clinical hypotheses. Clinical science made rapid progress under practitioners who included Bichat, Pinel, Louis, Laennec and Corvisart: the latter introduced percussion (discovered by Auenbrugger in Vienna) to routine clinical practice, while Laennec invented the stethoscope.

In contemporary England, examination of patients, even just inspection and palpation (never mind Dr Lydgate’s stethoscope in “Middlemarch”) was frowned upon. Indeed, in 1737, Queen Caroline had post-operatively succumbed to a strangulated umbilical hernia; bled, blistered, purged and cupped, her abdomen was only examined when King George II demanded it! The Revolution, and its wars, caused different effects in England. Wheat prices rose from £2.38 in 1781–90 to £6.32 for a quarter (28lb) by 1812. Justices meeting at Speenhamland in 1795 set a trend by agreeing to pay from parish rates a weekly sum based on the price of bread to every “poor and industrious person”, without the requirement to enter the workhouse. Expenditure on poor relief rose in Dorset alone between 1792 and 1831 by 214% (crime rose by 2135%). An American visitor noted that all English agricultural labourers were in practice paupers. Neither employee nor employer had any incentive to raise wages. A fall in death rates (probably due to better intrapartum care and vaccination) made matters worse, with the population of Great Britain growing from 11 million in 1801 to 16.5 million in 1831.

The 1834 New Poor Law addressed welfare dependency with the test of “less eligibility” — willingness to suffer the humiliation of entering the workhouse, be delivered there (like Oliver Twist) or die there (like Fanny Robin). The ritualistic disgrace of the workhouse funeral perhaps had a greater value to English society than the Parisian autopsy. Medical care to paupers was also restricted. Poor Law Guardians were advised that medical tendering was “the most desirable course”. As early as 1712, a Mr Aemilius de Pauw had tendered £12 for medical care of the whole Vestry of Woolwich, including medicines. Now, what was new was the vigour of the contracting — and the practitioners’ response in overcharging for any extra-contractual responsibility. By 1839, the neglect of the sick poor had become so scandalous that tendering was abandoned and Poor Law doctors got salaries, which must have met with particular relief in Scotland where Poor Law practitioners frequently went unpaid before 1834!

Jim Ford

...Napoleon introduced a national system of licensing in 1802...

Sources
4 G M Trevelyan. English Social History, 1944.
Many journals’ instructions to authors ask that abbreviations be kept to a minimum. In our view, that minimum normally should be none...

References


Abstract:

There is nothing that impedes comprehension as much as unfamiliar words.

So began an editorial in Nature, bemoaning the current state of nomenclature in molecular biology. Molecular biology has special problems because of the accelerating discoveries of new genes and proteins. The rest of medicine generates its unfamiliar words by abbreviations, which are mostly acronyms, formed by the initial letters of a substituted phrase. These abbreviations are useful as informal verbal or written shorthand within specialist groups. Outside these groups, the information, abbreviations confuse more than ease communication. In doing so, they keep outsiders outside, and encourage the fragmentation of medical science.

These are just some of the abbreviations from two issues of one general medical journal: CHD, AD, OCs, VTE, ATM, CIND, HIV, NEP, BMT, GvHD, ORT and HSR. We expect that every reader is familiar with one of these abbreviations (HIV), and that some readers are familiar with perhaps three or four. We doubt that any reader is familiar with them all. Any abbreviation must be defined at first use, but an abbreviation in an unfamiliar field may be forgotten by the time the page is turned, or even sooner.

If we exclude the motive of keeping outsiders out, why use abbreviations? There is no encouragement from journals. Many journals’ instructions to authors ask that abbreviations be kept to a minimum. In our view, that minimum normally should be none. This journal states that “abbreviations should not be used except for units of measurement”. We might also allow abbreviations so familiar that the full phrase is itself less familiar than the abbreviation. If we are charitable, perhaps this is why investigators use abbreviations but they must remember they are writing for others, for whom the opposite is true.

There is no encouragement for abbreviations from manuals of scientific style. O’Connor suggests using abbreviations “to replace lengthy terms that appear more than about ten times in a ten-page manuscript [which is about 2000 words], or that appear several times in quick succession, but don’t use more than four or five such abbreviations in a single paper.” She gives no definition of “lengthy”, but we suspect that oral contraceptives (OCs) and Alzheimer’s disease (AD) are not covered by it. Zeiger reckons that neither “heart rate nor norepinephrine is long or unwieldy”; HR and NE are common, and unnecessary.

Zeiger thinks abbreviations are “deceptive” and sums up why it is that writers like abbreviations but readers dislike them. “They make reading easier if you know them already [otherwise] they make reading a chore... [They] make writing faster and give the writer a feeling of belonging to a club... Remember, the goal is not to use abbreviations: the goal is clarity. Just because an abbreviation exists, that does not mean you have to use it.” Farr warns that “unless there is an international convention for a particular abbreviation you may only confuse your reader”. As an example of this, “We need to evaluate critically the efficacy of PE (with or without BSE) as an alternative screening method” is well suited.

Huth acknowledges that a more specialized journal is more likely to accept abbreviations widely used in its field even if the abbreviations are unfamiliar to clinicians in other fields. Zeiger allows DNA (deoxyribonucleic acid) in any journal, FRC (functional residual capacity) in a specialty journal, but IHE (isometric handgrip exercise) in no journal. Barrass is even more strict. He writes, “The names of journals are usually abbreviated in lists of references. Otherwise, only essential abbreviations should be used”, which comes down really to organizations (but NATO in French is OTAN), chemical names, research tools such as standardized questionnaires, and the accepted contractions of large multi-centre trials.

One of us has written previously that “A passage full of abbreviations is a sign of a lazy or hurried writer, not a marker of good scientific content.” Farr believes the use of abbreviations is “often simply verbal laziness”; Huth writes that “Some authors use abbreviations freely (and coin new abbreviations) because they are too lazy to write out full terms or to pause to decide whether an abbreviation is truly needed in a particular sentence.” He gives the example of “SLE patients” when, if no other conditions are discussed, the
adjectival “SLE” is unneeded.

Writers object understandably when they ask “Why do we have to write out the full phrase every time?” They do not have to. The phrase can be omitted, as SLE above. Sometimes the simple pronoun ‘it’ or ‘they’ suffices. If more than a pronoun is needed, once the ataxia telangiectasia gene (ATM in the list above) has been introduced, it can be referred to as ‘the gene’, with occasional repetition of the full phrase for emphasis. In an article about bone marrow transplantation (BMT), ‘transplantation’ suffices; if other organs are being transplanted as well, RT, HT, HT and BMT are no substitutes for the full phrases. Once a needle exchange programme (NEP) has been explained, ‘the programme’ is the noun to use; oral rehydration therapy (ORT) can be referred to as ‘therapy’; health services research (HSR) as ‘research’, or ‘this research’.

Fuller examples are more convincing. In the boxes are extracts from papers published in a general journal, and how we prefer to see them written. (Readers wishing to check the full context of the examples should contact us, bearing in mind that we could have chosen many other examples from many other journals.)

Investigators may not care who reads their papers (although we suspect they do), but surely the editorial staff do care who reads and understands their journals. General journals are read not just by medical staff reading more widely than their specialist interests, but by medical journalists and interested members of the public. Nature took the molecular biologists to task, and responses to their editorial suggest the problem of “acronym anarchy” is being taken seriously. Medical genetics is becoming increasingly relevant to all parts of the health service. It is an important part of molecular biology and one that many non-medical clinicians and the public need to understand. Writing of “cases of sporadic RCC suggesting screening for neoplastic cells by FISH” is gobbledygook. If editorial staff care about their readers, they must either ask their authors to think more about communication, or else wield the red pen themselves on RCC and FISH.

Neville W Goodman
Clifford Kay

Example 1
We analysed cells from a preparation with FISH with the P1 clone containing the von Hippel Lindau (VHL) tumour suppressor gene for detection of VHL-gene deletion. Allelic deletion of the VHL gene is not only seen in VHL disease-related renal cell carcinoma, but also in many cases of sporadic RCC suggesting that screening for neoplastic cells by FISH could be useful in many cases of RCC.

Example 2
The arrival of tacrine ... for use in Alzheimer’s disease (AD) ... prompted ... guidelines for the prescription of drugs for AD. ... We recommend the use of well-established clinical criteria for probable AD. The arrival of treatments for AD is a welcome development [and we] believe that the general guidance will be applicable to all drugs currently under clinical trial in AD. The arrival of tacrine ... for use in Alzheimer’s disease ... prompted ... guidelines for the prescription of drugs for the disease. ... We recommend the use of well-established clinical criteria for probable disease. The arrival of treatments for Alzheimer’s is a welcome development [and we] believe that the general guidance will be applicable to all drugs for the disease currently under clinical trial.

Example 3
It was into this cauldron that health services research (HSR) was introduced in the 1980s. ... All payers feel that HSR can help to solve ... increasing costs. But how realistic are these expectations of HSR? Will HSR prove to be a saviour ... or unrealizable dream? The aim of HSR is to provide unbiased, scientific evidence ... to improve the health of the public. It was into this cauldron that health services research was introduced in the 1980s. ... All payers feel that this research can help to solve ... increasing costs. But how realistic are these expectations? Will it prove to be a saviour ... or unrealizable dream? The aim is to provide unbiased, scientific evidence ... to improve the health of the public.

Example 4
Needle-exchange programmes (NEPs) [could] contain this epidemic, but they are not universally accepted. ... Despite these limitations, our study provides evidence that NEPs reduce the spread of HIV infection. With the theoretical mechanisms by which NEPs could reduce HIV incidence, and the interpretation of previous studies by the Panel on Needle Exchange..., the view that NEPs are not effective no longer seems tenable. Needle-exchange programmes [could] contain this epidemic, but they are not universally accepted. ... Despite these limitations, our study provides evidence that programmes reduce the spread of HIV infection. With the theoretical mechanisms by which they could reduce HIV incidence, and the interpretation of previous studies by the Panel on Needle Exchange..., the view that they are not effective no longer seems tenable.
Refugee Health. An approach to emergency situations. Medecins Sans Frontieres
MacMillan 1997
HB 380pp £5.85 (0 333 72210 8)

One of the resonant political and humanitarian issues of the last quarter of the 20th century concerns the rise of the refugee. Taking together those displaced across a national border with those displaced internally, nearly 1 in 100 of the population of the planet now qualifies — six times as many as in 1970. Mortality rates in the acute phase of displacement may be up to 60 times baseline rates. The vast majority of refugees are victims of violent conflict rather than national disasters, though the contributory effects of less spectacular but no less pervasive forms of social inequity and injustice — many the result of the impact of western economic philosophies on the least protected people on earth — should not be overlooked. In the 1990s between 40 and 50 of such conflicts were raging at any one time, almost routinely targeting civilians and their ways of life. In Africa in particular we witness a withering of the capacity of even well-meaning governments to deliver to their citizens, and the complementary rise in the role (and power) of aid and development agencies.

Medecins Sans Frontieres (MSF) has since 1971 grown to be a major player in this work, with something of a feisty or even gung ho reputation. It had offices in 19 countries and projects in 70 locations worldwide in 1996. This multi-author publication offers a comprehensive technical approach to health work in emergency situations, with an emphasis on operational priorities. It begins with a review of the backdrop, reminding us of the first known use of the word “refugee” in 1573 to describe Calvinists fleeing political repression in the Spanish-controlled Netherlands to join their co-religionists in France. It discusses the rise of an international protection system for refugees since 1951, the decidedly mixed blessings of refugee camps as institutions and the ambiguities of humanitarian provision when the international community also makes a military intervention — the Gulf war, Somalia, the former Yugoslavia. I was happy to hear their reminder that refugees are not just helpless dependents, victims incapable of independent action and choice.

The core of the book deals with the priorities in the emergency phase, which they list in order as initial assessment, measles immunization, water and sanitation, food and nutrition, shelter and site planning, emergency health and care, control of communicable diseases and epidemics, public health surveillance, human resources and training, and coordination. The text is full of solid technical information and points of reference, including core clinical signs which could serve as a basic guide to workers who did not necessarily have a health background. For example, in the section on nutrition, there is a list of the criteria to be considered in a decision to close a selective feeding programme.

There is a separate section on the post-emergency phase, which is defined as consultation with a gastroenterologist, not a ten minute NHS consultation with a GP registrar.

She had a choice of doctors. This a handbook for village health workers in developing countries, whose patients may only have access to a medical assistant after a twenty mile walk, and a doctor if they have HIV infection or need major surgery. It was developed for use in rural Mexico twenty years ago and has now been translated into more than fifty languages, proof of its practical value.

It is divided into sections on illnesses (with a new section on AIDS, sexually transmitted diseases and drug addiction), medicines and their dosages, and
beginning when the excess mortality of the emergency phase has been controlled and basic needs — water, food, shelter — addressed. Amongst specific issues, mention is made of reproductive health care, children, HIV and aids, tuberculosis and psycho-social/mental health. I have to say that the debate about the so-called psychosocial problems of refugees is conceptually muddled, though not only by MSF, and I challenge the basis for the statement that a considerable percentage of refugees will require therapeutic help to recover from their traumatic experiences. There is a real risk of an undue pathologization in assertions of this kind, and thus of interventions which refugees do not seek and which waste their time and our money. In my view there is at present no general case for seeing mental health as a distinct arena for humanitarian operations.

There is a further section on repatriation and resettlement, descriptions of the main communicable diseases and what to do, and examples of surveillance forms. All in all this is a book to be commended.

**Derek Summerfield**

*Poverty and health: reaping a richer harvest*  
Marie-Therese Feuerstein  
Macmillan 1997  
PB 215pp £8.50 (0 333 66130 3)

Most of the health planning advice directed at resource-poor countries is “top-down”, delivered by grey men in grey suits from grandiose offices in Washington or New York. This book is not like that: it is very “bottom-up”. The author spent 30 years working with the poor in Africa, South and Central America, East Asia and the Pacific region and has felt the reality of “sleeping on mats on earthen floors, eating maize pancakes and using pit latrines”. Her background is in health and community development and she pleads that any help for the poor must be based on a thorough understanding of local culture and values.

The connections between poverty and ill health are so entwined that it is often difficult to tease out cause and effect. Although community studies on poverty analysis are plentiful, the missing link is in understanding how poverty affects health at the household level. What do the poor have to endure in their everyday lives? How do they cope? Can a family afford to keep healthy? For example, at a community level, the rural poor may appear to be willing to pay fees for health care (judged by use of health facilities before and after the introduction of charges). But at what cost at a household level? Do they cut back on food? Do they sell their savings, or their cow, in order to pay? If they do, this may impact on their future health.

This book asks questions, it doesn’t give answers. “Go out there,” says the author, “speak to the poor. Find the answers from them.” Offering a clutch of checklists, maps and charts she describes how to go about it. Chapters cover the twenty main causes of poverty, how to identify the very vulnerable, which diseases hit the poor hardest, the cost of different elements of primary health care, and participatory monitoring, among much else. The text is divided into short, easy-to-navigate paragraphs punctuated with lots of delightful sketches.

But for whom is this written? Described as a “handbook for field use”, it covers a lot of ground in a fairly superficial way. It is definitely not a medical textbook: diseases are mentioned, but briefly and inadequately. For example, water-related diseases (schistosomiasis and guinea worm) occupy one paragraph. The role of health education in disease prevention is largely missing. The health section consists of a layman’s guide to some common diseases prevalent in developing countries, with advice on appropriate technologies to help diagnose and treat. Its strengths lie in descriptions of social policy and participatory monitoring and evaluation.

The poor are becoming poorer, and more numerous. Environmental degradation, inequitable land ownership, and the flood of migrants to cities have combined to undermine traditional survival and coping patterns. In both rural and urban areas the pace of change has been so rapid that people have had little chance to adapt. By the end of the decade two-thirds of Africans will live in absolute poverty without proper sanitation, clean water or health care. We urgently need to analyze the “pathology of poverty”, define its causes and find remedies and coping strategies. Maybe this book will stimulate some to do just that. It could be the first step in the right direction.

**Dorothy E Logie**

improving community health, and has a full index and a glossary of medical terms. Profusely illustrated with effective line drawings, it offers easily understood, down-to-earth advice on the management of almost all common conditions seen in developing countries.

Throughout, the authors stress the importance of prevention, for example by improving nutrition to avoid mortality from measles and TB, by breast-feeding to prevent diarrhoeal illness in infants, and by taking steps to avoid the harmful effects of traditional and Western medicine. The importance of clean water and effective sanitation is, rightly, a recurring theme. They emphasize working with traditional healers rather than trying to impose beliefs without discussion.

Obviously, the contents need to be modified for local circumstances and this is encouraged. The clarity of the text could be copied with benefit by other medical authors.

In Africa, I was impressed by the resourcefulness of village people in coping with desperate events happening to them and their families. This book advocates channelling that resourcefulness to best effect in a refreshing and non-patronizing way. In most of the world, poverty, ill health and high maternal and infant mortality rates are inseparable companions, and the authors do not shirk from repeatedly discussing the importance of inequity in land and food distribution and lack of education on health and disease. Here, there is food for thought for us in the comfortable North. Why do World Bank adjustment policies, driven by the developed world, continue to tie the poorest people in the world to poverty and ill-health?

For information on this and related issues like debt, the Jubilee 2000 web-site (www://oneworld.org/jubilee2000_email: 2000c@gn.apc.org) is well worth a visit.

**John Gillies**
Cricketers score runs, take wickets, and take catches. This is what they do, and so any cricket book tends to be a recital of statistics, usually permeated throughout by an almost nauseating insistence on the fresh air and good fellowship of it all. Robert Low’s biography of WG Grace fails, almost, into the statistics trap, but it is sufficiently distanced from the man and his era to stay on the right side of idolatry, and gives an interesting picture of the age in which he grew up, when cricket was gradually establishing itself as a great spectator sport, when the County Championship was evolving, and when communications began to allow sporting news to become more national. Grace came into the first class game at this time, slowly consolidating his place after an upbringing in a cricket-obsessed family whose tuition and supervision of him were as stern and thorough as in any conservatoire. He emerged from all this, fully equipped technically, to develop into a player of immense courage, smashing fast bowling into oblivion on dangerous pitches with batting that was essentially violent, brutal, and spectacular.

He became, early on, an icon — "The Champion", "The Doctor", "The Nonpareil" — his huge black-bearded physique and utter certainty of purpose and performance matching the arrogance and certainty of Victorian England. Trams were held up for him. The London Clubs emptied for him, with cabs clogging the roads to Lord’s and the Oval. Questions were asked about him in Parliament, and the press mirrored national amazement at his rare failures.

Grace was a paradox: an Amateur who yet made more money from the game than did any Professional, in ways that caused major friction more than once among Professionals with whom he played. He was not quite of the Amateur ilk; unlike so many of his colleagues, he was not born to the Imperial Purple of the Public School, Oxbridge, vast estates, titles, three initials, and double-barrelled names. Perhaps this social factor may have kept him from the England captancy at the height of his fame. Grace was of the professional middle class, eventually following the family tradition of medicine. It took him ten years to qualify, through the then chaotic Bristol Medical School (as well as Bart’s and Westminster), and he continued his commitment to cricket both as a medical student and as a general practitioner. His medical career lasted over twenty years; he did all his rounds on foot, and seems to have been a practical and compassionate physician.

As he aged, he became a National Treasure — fêted and honoured as one great batting performance succeeded another. He ended his days in a largely unsuccessful attempt to establish Crystal Palace as a centre for the first class game and continued to play until two years before his death in 1915, at a time when Victorian sporting ethics, spilling over so as to blur the distinction between life and sport, was on the point of disintegration in a world that had discovered both barbed wire and the machine gun. Grace, more than most players of his time, had been guilty of sharp practice contrary to that ethos, but these are the warts revealed in a sympathetic but clear-eyed portrait of a large and fearless figure, superlatively gifted physically, to whom the cricket bat was as another limb. His energy and appetite for the game were as phenomenal as his skill in all its aspects.

The old Derbyshire player, Clifford Gladwyn, once described his own share of a particular last wicket triumph in the words "cometh the hour - cometh the Man". Grace was a man who came at this hour, at a time and in an age almost waiting for such as he — and Robert Low’s text must be the definitive study of a sporting and social phenomenon, a man who become the country’s first truly National Sporting Hero.

Michael Lasserson
Gallstone Grove, tales from tomorrow.

**Episode 3: Media Training.**

Dr Max Phobius was in that sanguine and reflective mood so essential for a GP trainer. He was mulling over his forthcoming appearance before the Trainer Selection Committee precipitated by the premature departure of his Registrar. He still bore a smouldering resentment against Evangeline Fetlock, his Receptionist, who had set the debacle in motion. Lucinda Bradstock, the Registrar, had given her MRCGP consultation video to Evangeline for posting. Evangeline had unwittingly confused it with the video of the fist fight at her Silver Wedding celebration that she was sending to Jeremy Beadle.

Lucinda had been delighted to pass her MRCGP with Distinction, although she was puzzled by the Chief Examiner’s fulsome praise for her video, with its “daring experiment in family therapy”. She was less happy when she sat down to watch Jeremy Beadle to find the studio audience in paroxysms over Lucinda’s instructions to Mrs Spong for treating her piles. The high point of the show was her bittersweet consultation with Mrs Meehschaum weeping over her infidelity with a French onion seller some forty years ago, amid loud cries of “My Bert must never know”.

Whilst her appearance before the GMC was being televised for the same show Lucinda had her big idea. A few weeks later the first of a string of live medicine shows was launched. “Pendleton Rules” was a smash hit from the start. It was such a relief to have some alternative to cookery and gardening programmes. And the money flowed.

It was at this point that Phobius turned for advice to his old friend, Hubert Grauniad. “It’s the ethical issue that bothers me, Hubert.” Grauniad wasn’t having any of that. “No Max, it’s the bad taste that bothers you. If the programmes were on BBC2, presented by someone called Dimbleby then you would be the first to applaud their educational potential.”

Phobius was having one of those uncomfortable internal struggles that we like to call reflection. “Yes, but is it right to use the misfortunes of the vulnerable for entertainment? How autonomous is their consent if they need the cash?” “Max, let’s get real here. How autonomous is their consent for an insurance report? What sort of consent do they give for a junior clerk in the Health Authority to be instantly notified of their contraception and hysterectomy status? You’re missing the point. This new development is entirely ethical. It increases the happiness of society as a whole. It is an exquisite example of Utilitarianism.”

“But doesn’t Rawles say that we have to balance Utilitarianism with a Deontological model based on an individual’s rights? Unqualified Utilitarianism would defend gladiatorial combat as being a stabilizing force in a disordered society.” “Quite so Max. Oh, sorry - was I supposed to see that as a problem? Anyway, Rawles supposes that a group could judge an appropriate balance between rights and the common good if only they were blind to their own position in society. It would need a committee of amnesiacs. Sort of like the House of Lords. No Max, this is the way forward. Of course we must enshrine the rights of the individual, but we must reorganize the NHS according to the Utilitarian ethic as well. Aesculapius must be replaced by Jason, looking both ways.”

“Are you sure you don’t mean Janus, Hubert? And how can we guarantee adherence to both ethics when they are by definition contradictory? Surely society has to balance them, and share the pain equally?”

Grauniad sighed. “Max, Max, haven’t you heard — there’s no such thing as society. Let’s not quibble about the small print. If the Government didn’t think you could deliver both the greatest good for all, as well as to each one his rights, why would they give you the task?”

So now, as Phobius faced the Trainer Selection Committee, he felt a renewed sense of confidence in his destiny. Where was it all going to lead? Televised consultations may well have reached the point of terminal absurdity, but the future was bright. And just wait till they see the pay dirt in his Registrar tutorial video.

David Misselbrook
The Clinical Practice Evaluation Programme (CPEP) is an innovative approach to taking evidence-based standards into general practice and reflects the new emphasis on accountability for clinical quality in healthcare, set out in the recent White Paper. The Government has recognized that guidelines offer an important mechanism for helping healthcare professionals to deliver high standards of care.

Using evidence-based audit criteria, CPEP will enable general practice teams to evaluate, monitor and, for the first time, compare the quality and effectiveness of their patient care with practices in a similar health and social setting, both locally and nationally through a clinical practice network.

Professor Allen Hutchinson, Director of CPEP said: “The College is delighted to be at the forefront of developing higher standards for general practice. CPEP will very much be centre stage for the millennium and should lead to significant improvements in the quality of patient health care on a national scale. In the long term the data collated through the programme will build up a picture of the changing shape of general practice in Britain.”

The pioneering programme will address four of the key medical conditions treated mainly by GPs: coronary heart disease, asthma, depression, and diabetes. It will also help highlight areas of special need, such as cardiovascular disease, which may require additional attention and resources. CPEP will be coordinated by the RCGP with funding for the first two years of the programme being provided jointly by the NHS Executive and Merck Sharp and Dohme Ltd (MSD).

Dr John Young, Medical Director of Merck, Sharp and Dohme, said: “We are pleased to support this initiative. The provision of data to the prescriber as planned with this programme is important in achieving a steady and constant improvement in clinical decision making. MSD believes that it is an essential and legitimate role of the pharmaceutical industry to provide the highest possible standards of medical information and medical education, in addition to clinical research and the more recent focus on outcomes-driven research.”

The two-phase programme will have the following features:

- Evidence-based review criteria for use by practice team members
- A specially designed computer system for data collection and feedback
- Feasibility testing of the review criteria, data collection and feedback system
- Implementation of these evidence-based materials and data systems into general practice on a national level.

The first phase, involving the development of the evidence-based tools for effective care is now well under way. Feasibility studies, expected to involve around 200 practice teams, will be completed by late 1999. The extensive field testing will provide a blueprint from which to launch the second phase of the programme nationwide and is expected to be available to practices in January 2000.

Dr John Toby, RCGP Chairman of Council said: “The RCGP believes that quality in health care and clinical governance must be professionally led with general practitioners providing the drive and implementing of such standards. CPEP represents another strand in the College’s quality programme and will give GPs access to a confidential, reliable database through which to assess their own practice.”

GP Refresher Course -
Cuillin Hills Hotel, Portree, Isle of Skye, 25-29 May, 1998
Using resources in dyspepsia; Infection, the general medicine of the future;
Potting the Black, how can we use national guidelines; Of Lice and Men;
Youthenasia, drugs of addiction; Ethics from oats to consumers;
The psychology of the dying patient; How should we provide antenatal care...
Cost £200 - 8 sessions of PGE in a beautiful location!!
Details from Fiona Fraser, Postgraduate Administrator, North of Scotland Institute of Postgraduate Medical Education, Raigmore Hospital, Inverness
Tel 01463 705201 Fax 01463 713 454
diary

April 17-19
Spring Symposium (Exeter)
Tel 01395 567 808 or 01392 403 031

April 24
3rd National Conference Managing Drug Users in General Practice (Edinburgh)

May 5
National Study Day for FBA Advisers and Assessors Organized by Janet Bailey, FBA Administrator, Vale of Trent Faculty Tel: 0115 709 391 or Fax: 0115 709 389

May 11-15
International Course on Developing Teaching Skills-Module II

May 21
Research Symposium (Regent's College - London)

June 4
Study Day on Counselling in General Practice

June 4/5
GP Registrar Conference 98 - Primary Care: the Future (Bristol) Organized by Bristol VTS Members Tel: 0117 977 9477 or Fax: 0117 972 4345

Jun 11-14
WONCA (Dublin) Organized by the Irish College of General Practitioners Tel: +353 1 673 3706 or Fax: +353 1 676 5850

September 8-12
MRCGP Course

December 11
Study Day on HIV/AIDS

tbc Christmas Lecture

UNLESS OTHERWISE STATED, ALL EVENTS TAKE PLACE AT RCGP, 14 PRINCES GATE.

For further details of any of the above events please contact: RCGP Courses & Conference Unit, 14 Princes Gate, London SW7 1PU.
Tel: 0171 823 9703 Fax: 0171 225 3047 Email: courses@rcgp.org.uk

Rodger Charlton
A Solo Practitioner’s First Week

The staff kindly provided a celebratory drink and nibbles as I took over at one o’clock on the Thursday afternoon from the previous incumbent. We exchanged a few niceties and the work started at 2.30pm. I walked into reception. Mandy, the afternoon receptionist, asked if I would speak to a patient’s husband who was on the phone because his wife was proclaiming that she was an angel and was trying to fly out of a bedroom window. Even after the experience of eight years of group practice, I thought this was a joke and laughed trying to appear bemused. “Doctor, it’s true,” said Mandy. And so it was. My first patient required a mental health section to be implemented for her own safety.

The evening brought with it a learning experience. But first, another hoax call? “The inspector of the Inland Revenue is on the phone, because you have evaded the tax bill from your last practice, doctor,” called Mandy. I thought to myself, how can this be true? I am sure I have paid all that’s due and on time. I lifted the phone with a sinking feeling. The voice on the other end addressed me by name and repeated verbatim what Mandy had just uttered. “Jack”, I shouted, “stop messing about.” I recognized the voice of a practical joker who had been a friend at medical school and whom I had not seen for many years. Such was his unnerving welcome to the new area, where he too was a GP.

The first surgery brought out the village curiosities and challenges (some might say ‘heart sinks’). I suppose in a small rural community the residents want to size up their new doctor and be able to boast primacy in doing so! The first surgery and many to follow were a performance as I sized them up! It was time to make new rules and break old habits. “But Dr Jones always gave me my antidepressants without seeing me.” There had to be negotiation and diplomacy; my reputation depended on it!

A long evening was to follow as my very first patient escaped the social worker and psychiatrist, followed in hot pursuit by a police helicopter along the adjacent railway line.

Day 2 (Friday) before the weekend was Armageddon. Mr. Jacobs kicked the door open and his face was crimson. I was running half an hour behind appointments, which for my second day seemed not entirely unreasonable bearing in mind that I was working in an entirely new environment and a new health authority. As I looked up, Mr Jacobs shouted, at an extremely uncomfortable and threatening pitch, “This is a bloody shambles! How dare you keep me waiting half an hour. I am furious and I warn you I shall take half the village with me and we will register with another doctor. Your days are numbered.” I tried to speak, but I was not permitted. He then shouted, “How dare you!” and walked off slamming doors as he went.

All this was rather off-putting bearing in mind that the next patient was both timid, ill and in the process of miscarrying a late first-trimester pregnancy. I was now far from my best clinically as I tried to manipulate a new health system to gain hospital admission.

The last patient went, we locked the surgery and put on the alarm. I drove away from the village with trepidation and went up the long drive to Mr Jacob’s house at the suggestion of another long standing village resident. In the distance was a Rolls Royce with the number plate, ‘Jacob 1’. We drew alongside. I got out of my car, but, as before, I was not allowed to speak. “You’ve got bloody guts, I’ll give you that,” roared Mr. Jacobs.

I endured a sleepless night, not because of out-of-hours calls, but wondering what the next week might bring.

(Names of principal players have been randomized to maintain confidentiality)
Alan Munro

Work

William Morris, a Victorian socialist, thought that work above all should offer hope. He put hope of rest first, rest long enough to do more than merely restore strength, and so undisturbed by anxiety as to be enjoyable. Thus, he thought, we might be at least like the beasts. Next he proposed that there should be hope of a real product, one which we would regard as useful in our own lives. Then we would be doing as well as machines. Finally he wanted work to offer hope of pleasure in the exercise of mind, soul and body, in the engagement of memory and imagination and in the guidance of contemporaries and the men of past ages. If we worked thus, we would be men.

He did not have in mind, I feel sure, short term contracts, performance related pay, shift working, weekend working, junior doctors’ hours, and the levels of creativity generally demanded of employees in the late twentieth century. My impression of work, from conversations with patients from all sectors of employment, is that too often working life impoverishes the generality of existence.

Russell, in the middle of this century, suggested that “ends are no longer considered, only the skilfulness of the process is valued.....the modern world seems to be moving towards a social order representing the will of the powerful rather than the hopes of the common man.” It seems to fit. We buzz and buzz about like blue-arsed flies, skilfully not bumping into things, but permanently perplexed as we do the bidding of conglomerates, corporations and New Labour. Does their insistence on efficiency yield more than credibility for captains of industry and government to strut their stuff on global stages? Does it do much for the common man?

I now work part-time. This week I am resting. This morning I had a chat with my dung heap and did a bit of tidying up around it, heard a particularly good story from the postie, and went off on my bike to steal a few rhododendron seedlings from a nearby forest. Having done the digging, I sat against a tree and enjoyed the pale warmth of January sun. A red kite drifted by, languid wings stroking still air in gentle mockery of earthly, human affairs. Next week I’m working. Having been away for a while, I’m looking forward to finding out what my mates have been up to.

Michel de Montaigne retired, aged 38, in 1571, and invented the essay. “I resolved.... I could do my mind no better service than to leave it in complete idleness to commune with itself, to come to rest and to grow settled... . But I find that, on the contrary, like a runaway horse it is a hundred times more active.... . It presents me with so many chimeras and imaginary monsters that, in order to contemplate their oddness and absurdity at leisure, I have begun to record them in writing, hoping in time to make my mind ashamed of them.”

I do a bit of that too. Sometimes the BJGP even publishes conversations with my monsters. I would not pretend that this is a life of perfect fulfilment; some days the monsters are better company than others. Still, I do rate the combination of regular work and time for introspection and rhododendron-rusting quite highly. The practicalities? Certainly Montaigne’s estate to retire to and my working wife are considerable factors. Perhaps Henry David Thoreau should have the last word: “He is richest whose pleasures are cheapest”.

web site of the month

Greetings Doctor BJ

The wonderful worldwide web strikes again with another super new go-slower site from the USA: Medical Breakthroughs http://www.ivanhoe.com

This site is the Tomorrow’s World of medical websites, a hyperchondriacs dream, promising visitors that it is THE place to find lifesaving medical solutions.... I can’t see doctors all over the world binning their Lancet as a result of THIS site.

However, one useful feature is the ability to subscribe to their announcement service which promises to keep you up to date, via e-mail, of headline advances. So on that basis I might give it a try! Take MY advice Doctor and turn off the ‘autoload images’ for this one, and beware of patients bearing shards of medical breakthroughs.

Rob

www.schin.ncl.ac.uk

And remember, “when two events happen simultaneously pertaining to the same object of enquiry we must always pay strict attention”

Special Agent Dale Cooper FBI (Twin Peaks)