The Back Pages

viewpoint

The marketing conspiracy of Alan, Brian and Kevin

I DO not believe that there was a second gunman on that grassy knoll in Dallas in 1963; I do not believe that UFOs have been hidden by the US government; I do not believe in Father Christmas or the Easter Bunny. I do believe, however, that the medical professions are being misled by the pharmaceutical industry to the detriment of our patients.

'Do no harm' is our mantra, yet I have seen so much anxiety and distress caused by doctors. This is often caused by telling a patient that they have a 'risk factor' for a 'significant' disease or condition. We tell patients that we need to do further tests, then refer them to a specialist, then 'keep a close eye on them', then restrict their lifestyles. We tell them that they will need to take lifelong medication, perhaps two or three different agents. Their children will be 'screened' for the condition. If they become impotent as a consequence of treatment then that is acceptable, for treatment is too important to stop.

Now I may seem paranoid, but consider this scenario. There is a measurable risk factor called 'Brian' for a common significant physical event called 'Alan'. Brian is associated with Alan but is not causal. A pharmaceutical company spots that there are huge numbers of people with high levels of Brian in the general population and so develop a drug treatment called 'Kevin'. Universities are given grants to investigate and doctors become Brian specialists. A randomised controlled trial is conducted, looking at a population already at high risk of Alan but also with high levels of Brian. This is designed in such a way as to demonstrate even very modest benefits from the drug Kevin. After five years, Kevin just hits a statistically significant benefit for preventing Alan. Data are published with a positive spin, with a relative risk reduction of 30% of developing Alan by the drug Kevin. Marketing starts in earnest, with a raising of Brian's profile. Donations are given to form Alan pressure groups. Articles appear in newspapers and magazines talking about the potential dangers of Brian and this is personalised with accounts from patients talking about having Alan. Celebrities are paid to help the campaign and TV doctors have information spots on Brian. MPs are lobbied and offered 'appropriate' all-expenses 'fact-finding' trips to pharmaceutical research facilities abroad. Now Kevin is launched and newspapers are full of this new treatment. Local specialists give talks on the dangers of Brian, special machines testing for high levels of Brian are donated to hospitals and courses are offered by universities on Brian. At international conferences, we realise that we are 'years behind' compared with the United States on treatments for Brian. The debate on 'screening' for Brian begins and health economic modelling suggests this may be cost effective.

So a new chronic disease is born called Brian, and surgeries are full of concerned patients. Doctors feel under pressure to do something about Brian as emotional column writers of newspapers talk of a 'silent epidemic' and a 'time bomb' in the making. We refer, we investigate, and we treat. Lots and lots of people receive Kevin to treat high Brian levels. Does this sound familiar? We have now made Brian into a medical condition himself, when in the past he was one of a number of risk factors for Alan.

Consider, however, that the patients in the RCT are not typical of your own. Consider also that, when annualised, the numbers needed to treat in order to prevent Alan by treating Brian with Kevin, is over 300. Crudely put another way, a patient would need to take Kevin for 300 years to prevent Alan. Oh, and did I forget to tell you that Kevin costs £30 a month, which is £360 a year, which works out at £108 000 per year to prevent one Alan?

Poverty is the main predeterminant of ill health and most diseases are multifactorial in origin. Consider that the basic pension is £72.50 for a single pensioner, and £115.90 for a couple. Is this really the best use of our money, or is it just marketing and profit?

Doctors repeatedly overestimate the benefit of treatment of risk factors. This establishes a cycle of anxiety that leads to treatment, investigations and follow-up. There are huge financial vested interests in making us sick.

Des Spence

Further reading

1. See **www.nofreelunch.org** and take the pledge!
2. See work by Ray Moynihan at **www.bmj.com**

"In the year 2000, more was spent promoting the drug Vioxx® (rofecoxib) (US$ 160.8 million) than PepsiCo spent on promoting Pepsi® (US$ 125 million) ..."

Les Toop, Dee Richards, Tony Dowell on Direct-to-Consumer Advertising, page 342

contents

Rural doctors and nurses working together

In January, the RCGP's Rural Group hosted a workshop at Princes Gate for rural doctors and nurses. We wanted to explore how teams really work together, what works well and what doesn't, how far we have gone with changing the skill mix, and to encourage nurses in rural areas to identify the particular issues facing them in their work.

The day was a great success: there were presentations by Jim Cox, who founded the Rural Group; and by Lynn Young, Primary Care Adviser to the Royal College of Nursing; however, the bulk of the day was spent in workshops. Much common ground was identified — one of the firm resolutions from the day included a move towards developing a rural group within the RCN, and the welcoming of nurses into our web discussion group (**www.RCGP_rural_group@yahoogroups.com**).

Below are some of the issues that were discussed:

Skill mix

- Nurse practitioners. Shared higher level skills brings innovation, and can increase the skill of others, e.g. GPs and other nurses.
- The importance of communicating well, e.g. written reports.
- There are considerable skill-mix issues for isolated patients (division of labour, although appropriate in a large urban practice, may not be efficient in a large remote area, where the professional on the spot may need to undertake some tasks that could otherwise be taken on by less qualified colleagues).
- Everyone agreed that change was necessary in many ways, and that there are significant practical problems, not least with funding.
- Flexibility is important; many people in the team are prepared to undertake each other's normal work occasionally.
- Active patient participation is very helpful.
- Adequate funding is fundamental.
- Team meetings are essential — the more inclusive the better.
- Multidisciplinary training and working.
- We need to be prepared to task up as well as down. It is important to delegate control as locally to the patient as possible, e.g. to home helps.
- We should adopt problem-oriented, open and imaginative, collaborative, and patient-centred approaches.
- Innovation can be helpful, e.g. use of telemedicine in community hospitals.

Some examples of bad team work:

- The 'urban-centred diktat' — local decision making and management is just as important in rural areas; the issues and priorities may be very different to those of the majority of their colleagues in non-rural areas.
- Delegation of responsibility without offering any control. The hierarchical structure, particularly of nursing, means that well thought out local solutions can become threatened. A source of frustration is that doctors can make many decisions, but nurses frequently have to have decisions made at their trust level.
- Lack of educational opportunities, sometimes because of funding. We need to recognise that not all GP employers are enlightened; some could be described as recidivist, recalcitrant, self-opinionated, anarchic, and exploitative!
- There can be a lack of appreciation of longitudinal care.
- The 'consultoid' approach is not always restricted to poor consultants and we need to recognise each other's training, experience and skills and show mutual respect.
- Target-setting to excess can be destructive.

Some solutions for improving team work:

- Common goals.
- Clearly defined boundaries.
- Picking a good team and developing talent (occasionally, poor team work can be because of a wrong mix of people. Successful teams, e.g. in football, select well and train for team work).
- A holistic approach is important.
- Patient-held records can be useful.
- A common goal should be to be patient-centred.
- We need excellent communication, both with patients and other professionals.
- We need more time, which means investment in people, more staff, and more money.
- We need to try to meet and understand colleagues — 'an enemy is a stranger whose story you haven't listened to'.

So, we made a good start, but we now need to keep up the momentum.

Iain Mungall

Course on Cross-cultural Primary Care, University College London

THE aim of the course is to equip those working in primary health care with the skills necessary to understand the health beliefs and practices of different patients and communities, and how these may differ from their own.

The course is open to all those working in primary health care settings. Topics covered include:

- Patients' explanatory models of illness;
- Body image and interpretation of symptoms;
- Family structure and family health;
- Pregnancy, childbirth, fertility and infertility;
- Death, dying and bereavement;
- Alcohol, tobacco, and drug abuse;
- Use of non-medical health care;
- Cross-cultural psychiatry;
- Nutrition, malnutrition, and dietary taboos;
- Migration, refugees, stress and disease;
- HIV/AIDS and other sexually-transmitted diseases

The course will be taught by Dr Cecil Helman (Senior Lecturer, Department of Primary Care and Population Sciences, Royal Free and University College Medical School). The session on AIDS will be given by Dr Surinder Singh.

The course will take place in the Department of Primary Care and Population Sciences of the Royal Free and University College Medical School, Holborn Union Building, Highgate Hill, London N19 5LW. It will run from 28 April to 2 May and will consist of five full-day sessions. For dates of subsequent courses, please contact the Course Office.

Cost
Full-time GP and hospital consultants: £600
Part-time GP, non-principal GP, or other hospital doctors: £500
Nurses, and those working in non-medical professions (including charities, non-governmental organisations, local councils, government bodies, refugee organisations, ethnic minority organisations): £450

Postgraduate Education Allowance
A Certificate of Attendance will be given to all participants. PGEA approval applied for.

For further information please contact:
Pauline Conroy, Department of Primary Care and Population Sciences, Royal Free and University College Medical School, Holborn Union Building, Highgate Hill, London N19 5LW; tel: 020 7288 3474; fax: 020 7281 8004; E-mail: p.conroy@pcps.ucl.ac.uk; URL: **www.ucl.ac.uk/primcare-popsci/courses**

flora medica theophrastus bombastus

From the journals, February 2003

***N Engl J Med* Vol 348**
518 How many human papillomaviruses can cause cervical cancer? You might think the answer is two or three, but this study finds 18 serotypes.
529 You can't understand where medicine is going without genomics: here are two papers you could start with. Then move on to *Lancet* **361:** pages 567 and 598.
583 An Australian study, publicised as showing that ACE inhibitors are better than thiazides in hypertension. Actually, the difference is hardly significant: the amount by which blood pressure is reduced is always more important than the agent you use.
781 Multiple ventricular ectopics during exercise are less predictive of death than those which occur in the recovery phase.

***Lancet* Vol 361**
394 Beware: *Haemophilus influenzae* epiglottitis is making a small comeback, and booster vaccination may be with us soon.
407 Eating disorders get a good review: half of them are atypical and the evidence base for their management is vanishingly slim.
449 An important controlled trial finds that a salmeterol/fluticasone combined inhaler is effective in chronic obstructive airways disease.
471 Sexually abused men do not usually go on to be abusers: 26 out of 224 were identified in this study.
653 Once seriously depressed, always in need of antidepressants? Here's a systematic review that tends to this conclusion.
662 Buprenorphine is a partial opioid antagonist and can cause nasty withdrawal reactions when used in high doses for heroin replacement, but this Swedish study shows very good one-year results from a 16 mg fixed-dose maintenance regime.
672 Population data showing the great success of meningococcal C vaccination in the UK.
690 Itch: the review you were scratching about for.

***JAMA* Vol 289**
579 If you drink enough alcohol to protect your heart, are you more likely to get a stroke? Not at all: the protective effect is similar.
712 If you had a patient with stable advanced heart failure, would you dare to give a beta-blocker? You certainly should, as it will not only improve function but also reduce mortality (COPERNICUS).
730 And would you think of referring a heart failure patient for ventricular resynchronisation? Again, you should, because many will live longer and function better (systematic review).
854 But don't bother with digoxin if your heart failure patient is in sinus rhythm: it may actually increase mortality in men with serum levels above 1 ng/ml.
895 'Is this Woman Menopausal?' Not a very delicately put question, but a very helpful guide to decision making.

Other Journals
***Arch Intern Med* 163:** the USA has caught up with Europe in looking for coeliac disease, and levels there are the same as elsewhere, i.e. up to ten times higher than previously thought (page 286). Statins may pay for themselves by reducing the economic burden of cardiovascular disease (page 333). Non-influenzal respiratory viruses are the most common cause of human illness: this study assesses the economic impact (page 487).
***Ann Intern Med* 138:** there's a whole issue agonising about the future of primary care in the USA, with a particularly thought-provoking paper on page 262. For the latest management of venous ulcers, go to page 326.

***AORN* 77: 396** reports the relaxing effect of music chosen by patients undergoing minor surgery under local anaesthetic: but what's the effect of their choice on the doctor?
The New Zealand author Janet Frame wrote an unforgettable personal account of undergoing repeated electroconvulsive therapy without anaesthetic, and 50 years later the ***Aus NZ J Psych*** collects modern accounts, containing less horror but much anxiety (**37: 49**). There is even a whole journal devoted to ECT — the *Journal of Electroconvulsive Therapy*, now into its 19th electrifying volume.

***Gut* 52: 260** identifies non-steroidal anti-inflammatory drugs as a frequent cause of acute diarrhoea. ***Thorax* 58: 110** reports a brief physiotherapy intervention for asthmatic patients with dysfunctional breathing patterns. Worth trying in this difficult group — more than 25% maintain benefit at six months.

The ***Can J Rural Med* 8: 25** looks at the prevalence of falls in elderly rural Canadians, and finds it similar to city dwellers, though they comment that the causes may be different. Bears appearing at the cabin window, for example.

Plant of the Month: *Magnolia cylindrica*
There is learned debate about this plant, introduced to England under this name in the 1920s and still rarely seen. It may be a hybrid with *M. denudata*, but that's never a bad thing, and it has lovely fragrant white chalices now and rather rude-looking red sausage fruits in autumn.

THE medico-political history of general practice education has been explored in some detail. This includes the years between the formation of the NHS and the Family Doctors' Charter, identified as a time of decline, before the College of General Practitioners' strategic decision to concentrate on training took effect[1,2] and before the emergence of undergraduate teaching.[3] In Scotland, general practice education has had a particular historical significance. The earliest experiment in joint training, linking hospital and general practice, was pioneered in Inverness in 1952.[4] The first department of general practice was founded in a dispensary practice in 1948 in Edinburgh, with the first chair appointed in 1963. England only slowly followed suit.[5] The Edinburgh department provided an important resource for the Scottish Council of the College of General Practitioners, and it was members of the Scottish Council whose efforts were instrumental in the introduction of a membership examination.[6]

By the late 1960s, the voluntary trainee practitioner scheme, established with the formation of the NHS, was on the verge of collapse, with trainees complaining of the lack of teaching and their exploitation as 'an extra pair of hands'. In contrast, the introduction of regional advisers in 1972 and mandatory vocational training nine years later not only strengthened postgraduate education, but also ensured its separate and rapid development. While it was also a time of growth in the numbers of departments of general practice, postgraduate education proved more significant to rank-and-file practitioners.

The interviews with the Paisley GPs suggest that prior to the voluntary scheme there were informal arrangements, which involved teaching hospitals and local practices providing work experience for students. More importantly, while it is significant that the Local Medical Committees (LMCs) agreed to hand over responsibility for trainers to the universities in 1973,[7] the oral histories also provide evidence of a greater degree of continuity than has so far been acknowledged. The relationship between LMCs and local College activists in Paisley was described in contemporary committee minutes relating to educational matters, and in subsequent recollections, as constructive, with agreements reached on important issues. This process is said by the GPs to have been assisted in the west of Scotland by a number of key LMC activists holding College memberships.

The interviews uncovered the ways in which education was a significant mechanism in the transmission of new ideas, techniques, values, and attitudes between generations of doctors. Differences were found between the official policy and what was being taught at a practice level. Even after assistantships were replaced by vocational training, apprenticeship in its broadest sense continued. The interviews suggest that knowledge in academic general practice was not based on clinical and other technical skills alone. Rather, other issues, such as power and authority in education,[8] power in practice (including partnership structures), and the moral environment in which educators and students operated were also often referred to in the practitioners' narratives.

The character of the early developments in Scotland also encouraged the emergence of distinctive organisational structures. These included the formation of the Scottish Council for Postgraduate Medical Education (1970) as a non-statutory body, fulfilling the co-ordinating role recommended by Todd Report (1968). Increasingly, there were attempts to introduce more formal teaching along with the evaluation of those practitioners, and their practices, aiming to achieve training status. Paisley's family doctors have often felt themselves part of innovative developments in general practice education, especially given the West of Scotland's lead in championing standard-setting, including A4 record keeping, and more recently in new methods of assessment that test minimum competence.[9]

As postgraduate education developed, including the introduction of paid Associate Advisers in the mid-1980s, some of the GPs in Paisley reported that they had begun to feel that training had become an exercise in 'empire building' — a phrase used by a number of practitioners. The cyclical histories of practices, including changes in partnership and other team members, has meant that practices cannot always meet the demands made by postgraduate education. Having a turnover of training practices is a way of spreading good practice, although the interviews suggest that the doctors who serve the most deprived sections of Paisley's population are much less likely to become trainers.

Service GPs have long recognised the educative value of having students or trainees around their practices.[10] However, there were clearly stresses and strains emerging in the 1980s between the culture of everyday practice, including the importance older GPs found in experiential learning[11] and the attempts to develop new methods of training that were being developed by a postgraduate department clearly aiming to improve training provision. Evidence of such tension reinforces suggestions that despite the considerable success of academic general practice, the identity of the discipline remained problematic.[12,13]

References
1. Swift G. Postgraduate education and training. In: Fry J, Horder J, *et al*. *The History of the Royal College of General Practitioners: the first 25 years*. Lancaster: MTP, 1982.
2. Pereira Gray DJ. Postgraduate training and continuing education. In: Loudon I, Horder J, Webster C (eds). *General Practice under the National Health Service 1948-1997*. London: Clarendon Press, 1998: 182-204.
3. Hannay DR. Undergraduate medical education and general practice. In: Loudon I, Horder J, Webster C (eds). *General Practice under the National Health Service 1948-1997*. London: Clarendon Press, 1998: 278-284.
4. Adams AR, Gaskell PG, *et al*. A postgraduate training scheme in Scotland. *BMJ* 1954 **(Suppl) 24 July:** 2583-2584.
5. Rivett G. *From cradle to grave: fifty years of the NHS*. London: King's Fund, 1998.
6. Lawson JAR. The Royal College of General Practitioners: its growth and influence over the past 40 years. *Br J Gen Pract* 1992; **42:** 210-211.
7. Pereira Gray DJ. *Training for general practice*. Plymouth: Macdonald and Evans, 1982.
8. Freeling P. Those who can. *Br J Gen Pract* 1978; **28:** 329-340.
9. Pereira Gray DJ. Postgraduate training and continuing education. In: Loudon I, Horder J, Webster C (eds). *General Practice under the National Health Service 1948-1997*. London: Clarendon Press, 1998: 194-195.
10. See for example GPP 02 and GPP 30.
11. Smith G. An oral history of general practice 5: Gender and narratives of profession. *Br J Gen Pract* 2002; **52:** 483; 868-869.
12. Reid M. Marginal man: the identity dilemma of the academic general practitioner. *Sym Int* 1982; **5:** 325-342.
13. Marinker M. Journey to the interior: the search for academic general practice. *J R Coll Gen Pract* 1987; **37:** 385-387.
14. GPP 16.
15. GPP 27, according to Douglas H, the scheme was established in 1978, five or so years after the Southern General Scheme that he had worked on in the early 1970s.
16. GPP 10.
17. GPP 19. GPP 15 makes a similar point.
18. GPP 06.
19. GPP 05.
20. GPP 05 and GPP 12.
21. GPP 12.
22. GPP 28.
23. GPP 27.
24. GPP 09.
25. GPP 22.

The oral evidence
In the early 1970s, Douglas H (who was shortly to become a Deputy Regional Advisor) was involved in a series of postgraduate education meetings in the West of Scotland.

Douglas H: *'There was a fair bit of niggle between the College and the LMC … The LMC were reluctant to allow some other body to come up and say this is what should be done, although they had no axe to grind in that they didn't have anything to do with training GPs, just appointing them. They had to be persuaded …*

'I think the motivation really was to see general practice get onto a higher plane than it was on … If you are producing better trained doctors across the board it will raise the standard.'[14]

Gerard D was one of the early trainers.

Gerard D: *'In those days* [c. 1974] *it was not uncommon for GPs to be talked down to … and I felt we should get involved in teaching … And eventually folk would come to Paisley to do their house jobs to get on to the Paisley scheme but it was the general practice side of it that was the bit that actually attracted them and the bit that was good … I eventually became* [c. 1985] *the Associate Adviser for the Renfrew District Scheme …'* [15]

The early trainers believed that inculcating values and attributes was at least as important as passing on skills. Like others, Charles Mc believed that undergraduate and postgraduate hospital education would teach clinical skills, whereas his job was to teach the 'human element'.[16] Early trainees appreciated such teaching.

Damian S: *'Stuff they can't teach you in a book: how to talk to people; how to listen to people; what to do with this condition … It was like an apprenticeship in general practice.'*[17]

For those who entered practice in the late 1970s and after, postgraduate education in general practice was often described as the most useful component of training.

David R: *'The hospital training was relatively much less useful than the GP training … Okay, there were a few things that I picked up through working in the hospital that I might not have been able to pick up otherwise, but it's a very inefficient way of learning things about work in general practice.'*[18]

But members of the same cohort were also more likely to question their training.

Brian R: *'He* [the trainer] *was never particularly critical of me, but as soon as I expressed an interest in the business side of general practice he did say that, "The business aspect is probably the negative aspect that's crept in".'*[19]

While home visiting was justified at some length by trainers, the registrars were unconvinced and would often dismiss return visits, in particular, as 'social service'.[20]

There were problems of learning experientially with a single trainer.

Eleanor H: *'If you work with a general practitioner, that becomes your template. That is what you think is the norm … My trainer was nice, but it was learn by example. I particularly remember one experience* [c. 1978] *when I didn't know what to do on a house visit and he said, "Och, send him in". And that was not the level of advice I was looking for; I could have made that decision myself … I wanted him to come and discuss … I think he was just too busy to offer me the kind of support that I was looking for … as I say the first six months I don't think I got huge amounts from my experience of general practice … But we did have a half-day release programme and I got a lot from that. That was good and well organised ... a good experience and I enjoyed that and it put you in touch with all the registrars in the area and we shared experiences.'*[21]

Fiona T: *'I was very unsure of myself and I think he* [the trainer] *sensed that and so he thought it would be better if I just kept following him around* [laughing]. *I had got into the spiral of despair that this was all I was going to do* [laughing]. *He was marvellous from the point of view of learning by example. Sort of an old apprentice style … And I learned lots … very many wise things from him … I just remember him asking obscure questions and sort of sniggering at me, because I didn't know the answers … it didn't work with me — humiliation doesn't … it just made me feel abysmally stupid and* [laughing] *I just avoided him for the next few days, so I wouldn't be asked anything else … That sounds very critical and I am not, because I think that was the way training was. And I think it has changed and we're looking at it in a different way now. And I think I got as good a training as anybody got, and better, in the sense that his patience and his willingness to listen to people is something that rubbed off on me. And I think it serves me very well and if I learnt nothing else directly from him then those were great things to take forward.'*[22]

In the past two decades, training has been used increasingly and more directly to raise standards.

Gerard D: *'And if you came to join my practice or hoped to be a trainee in my practice, I was dictatorial as well. I would say, "If you come here you will sit the College Exam." … But I think things like exams, like audit and all the rest of the things, like videoing, like formative, summative assessment, it's put more and more pressure on the trainees … So it's really a fairly stressful period for them now.'*[23]

David D: *'We're quite disappointed at the way aspects of the requirements for being a training practice have gone. They've really made it very difficult for practices like ourselves to live up to these requirements … When I came to the practice it was still quite worthwhile to the practice in financial terms to have a trainee and there was a significant service element to what the trainee did at that time. Trainees did out-of-hours work … And, I'd certainly have major misgivings about trainees or registrars completing a year and not having had the realistic exposure to what a principal does … In the last four or five years I'd say the income from* [laughs] *being an accredited training practice was really of no interest to us. It was all about the workload that it had created for us and ultimately we just felt that we couldn't sustain that.'*[24]

Training continues to be associated with professional status in relation to hospital medicine, but it also has become a mark of status within general practice itself.

Colin R: *'So it's sort of telling people that we are pretty good. We're maybe not the best and it's not saying that non-training practices don't do good jobs, but at least every three years we get tested and we're achieving a standard. It is a status thing … So we became trainers I think about '84, '85 I think it was our first trainee came through. And of course in the old premises it was difficult. In the old premises no matter how good we were we wouldn't be a training practice because we just physically didn't have the space.'*[25]

Audio extracts from the interviews can be listened to as sound files on the ScHARR website: http://www.shef.ac.uk/~scharr/hpm/GS/

Problems with DTCA

- **Inability of brand advertising to provide appropriate and balanced information**
- **Deleterious effects on health funding and resources**
- **Negative effects on patient–clinician relationships**
- **Patient safety concerns from increased exposure of patients to new drugs**
- **Inappropriate medicalisation of well/healthy populations**
- **Lack of evidence demonstrating the claimed benefits of DTCA**

Recommendations

- **That the New Zealand government introduce regulations and/or legislation to prohibit the advertising of prescription medicines directly to the public, through print and broadcast media or any other means**
- **That the government establishes an independent medicine and health information service free of commercial interest**

dtca 1

'The power and sophistication of the pharmaceutical industry cannot be underestimated. Those who seek to counter it in the public interest need more than commitment and energy ... In the absence of strong advocacy in the public interest, the pharmaceutical industry will continue to set the tone of public debate.'

Rt Hon Helen Clark 1992 (New Zealand Minister of Health 1989–1990, Prime Minister of New Zealand 1999–present)

THERE is a long and proud tradition of general practice speaking out in an advocacy role on issues of public health importance.[1-3] In recent years, this function has increasingly been subsumed by the effort needed to survive repeated health reforms and an increasing bureaucracy. Similarly, the core role of academics within universities to act as critic and conscience of society has diminished in many countries. Hardly surprising, perhaps, as the scramble to put as many students as possible in classes and to maximise research performance become the overriding drivers to the financial survival of universities around the globe. It is always easier to complain about frustrations, to shrug shoulders and to push on with the immediate job in hand.

However, some issues are impossible to ignore, particularly when, as in this case, the activity is spiralling out of control. It is the responsibility of all doctors to speak out when the commercially-driven pressure for profit puts at risk the health and safety of patients, undermines the trust and co-operation built up between patients and their

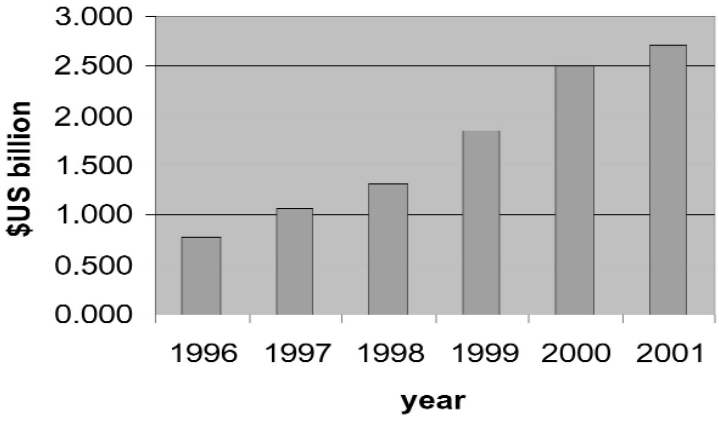

Figure 1: *US spending on DTCA 1996-2001. Source: US NIHCM Report 2001, and US General Accounting Office Report to Congress, 2002.*

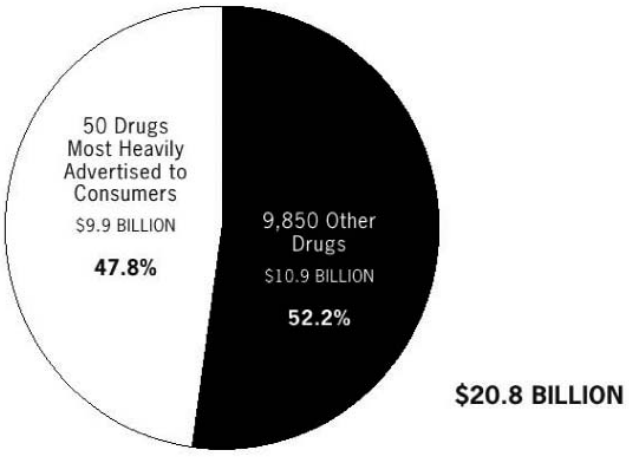

Figure 2: *Increase in retail prescription drug sales 1999–2000. Source: American Institutes for Research analysis of competitive media reporting data, cited in June 2001 in* Med Ad News, *and Scott Levin Year 2000 prescription audit data.*

doctors, and threatens the equitable distribution of resources in already stretched publicly-funded health systems. Direct-to-consumer advertising (DTCA) of prescription medicines does all of these things. It is a growing and powerful influence (Table 1). Indeed, responders to a recent Minnesota Medical Association survey ranked it as the most important pharmaceutical issue affecting the practice of medicine today.[4]

New Zealand and the United States are the only two countries in the Organisation for Economic Co-operation and Development that allow DTCA of prescription medicines. In New Zealand this can be attributed to the absence of legislation or regulation to prevent it. It is only in recent years that the pharmaceutical industry has fully realised the potential DTCA has to increase sales. Several other countries are considering liberalising their regulations. A number of countries, including Australia and Canada already have pharmaceutical company-funded direct-to-consumer disease awareness advertising, which, when combined with 'industry-funded consumer groups,' has much the same effect as brand advertising.[5] This has already started in the United Kingdom (UK) and mainland Europe, with industry-sponsored men's health groups raising the profile of sildenafil, and Pfizer also accused in a recent *BMJ* of not just 'disease awareness' advertising but, in the case of 'female sexual dysfunction,' disease invention.[6] The pharmaceutical industry benefits from the way in which medical journals press-release significant papers. GPs in the UK report having patients inquiring about Losartan® after reading about it in the press on the very same day that the research papers were published in the *Lancet*.[7]

The European Union Parliament has recently rejected, by a 12-1 majority, legislation aimed at liberalising DTCA in Europe.

The volume and expenditure on DTCA is increasing exponentially, both in the US and in New Zealand, using ever more creative ways for manufacturers to directly contact and advertise to consumers. The explicit aim of DTCA is to drive patients to their doctors with requests for specific brand name patented drugs. DTCA is unquestionably effective[8] and sales of advertised drugs are rising disproportionately. In 2001, US$ 2.7 billion was spent on DTCA[8] (Figure 1) and the top 50 advertised drugs accounted for 50% of increased expenditure[9] (Figure 2). In the year 2000, more was spent promoting the drug Vioxx® (rofecoxib — US$ 160.8 million) than PepsiCo spent on promoting Pepsi® (US$ 125 million).[9]

Drug	Condition	DTC spending (millions US$)	Sales (millions US$)
Vioxx® (rofecoxib)	Arthritis	160.8	1518.0
Prilosec® (omeprazole)	Ulcer/reflux	107.5	4102.2
Claritin® (loratadine)	Allergy	99.7	2035.4
Paxil® (paroxetine)	Anxiety/depression	91.8	1808.0
Zocor® (simvastatin)	High cholesterol	91.2	2207.0
Viagra® (sildenafil)	Impotence	89.5	809.4
Celebrex® (celecoxib)	Arthritis	78.3	2015.5
Flonase® (fluticasone)	Allergy and asthma	73.5	618.7
Allegra® (fexofenadine)	Allergy	67.0	1120.4
Meridia® (sibutramine)	Obesity	65.0	113.2
Total		924.3	16˚347.8

Table 1: *Products with top DTC advertising budgets in the United States (2000).Source: US NIHCM Report 2001.*

Disquiet over developments in DTCA in New Zealand triggered a Ministry of Health discussion paper on DTCA for prescription-only medicines in 2000. Following a round of submissions, the Ministry of Health recommended that the regulations on DTCA be tightened.[10] To date, no action has been taken. Around the time of this review, the voluntary self-regulatory framework was expanded to make the industry-run pre-vetting system 'mandatory' for broadcast advertisements. This was in response to the repeated breaches of regulations occurring in direct-to-consumer advertisements. This system includes the option of companies having delegated authority to pre-vet their own advertisements. There is no brief or resources for any independent or central regular monitoring of DTCA compliance with the Medicines Act and Regulations. Investigation of breaches only occurs in response to complaints. Not surprisingly, breaches have continued.

A particularly high profile TV campaign by one large company to underpin a commercial decision to withdraw their range of beclomethasone metered dose inhalers in September 2002 employed a controversial and, in the view of many observers, misleading television advertisement campaign, which encouraged users of beclomethasone inhalers to visit their doctor to 'upgrade' to a 'superior' (and more expensive) fluticasone inhaler. The advertisement included an inducement to collect a free inhaler.[11]

Prompted by the anger expressed by many general practitioners over this campaign, we decided to review the international literature on DTCA. It quickly became clear that almost every independent group that has reviewed DTCA had arrived at the same conclusion: that it is not of net benefit to the public health. Indeed a number of commentators and reviews have concluded that it represents a threat to the health of the public and to the viability of publicly-funded health systems. The interested reader wishing to read deeper could usefully start with the report from Meek for the British Pharmaceutical Society,[12] the work of Barbara Mintzes and others at the University of British Colmbia,[13-16] the UK consumer campaign (**www.which.net**) and the web-site of HAI (**www.haiweb.org**), a European-based alliance of consumer associations. A browse at the websites of Public Citizen in the US (**www.citizen.org**), the US Food and Drug Administration warning letters (**www.fda.gov/cder/warn**), and a US Congress report on oversight of DTCA in the US[8] illustrates the problems of controlling DTCA in the US.

Three of the four New Zealand professors of general practice visited the Minister of Health in September 2002 to voice their concerns and to suggest that the misinformation provided by brand advertising should be stopped in favour of more independent and comparative health information. The Minister herself expressed concerns about DTCA and the lack of action in tightening the oversight of the self-regulatory system. The delegation was advised to provide a written summary of evidence to support the case for a ban and to assess the level of public and professional support for such action. The group was expanded to six authors, representing the academic general practice departments of all four New Zealand medical schools. The final report containing the evidence to support a ban was presented to the Minister of Health in February 2003 and may be downloaded from **www.chmeds.ac.nz/report.htm**.While it was being compiled, the group visited a number of key professional and independent consumer associations, who agreed to reconsider their positions. At the same time a consumer survey was commissioned,[17] which used questions adapted from the UK Consumer Association survey in 2002.[18] This found similar levels of mistrust for pharmaceutical advertising to those of consumers in Britain.

Case Study: Diane-35® (ethinyloestradiol plus cyproterone acetate) 34

Diane-35®, an anti-androgen/oral contraceptive pill, was marketed as a solution to problem complexion, with wording similar to that used in cosmetics advertisements.

Headline: 'Restore the natural balance of your skin with Diane-35®'

'Tried every treatment known to woman? Diane-35® is an effective solution for problem skin that is proven to be 93% effective.'

The contraceptive effects of Diane-35® were mentioned only in the small print and in even smaller print at the bottom of the page 'Diane-35® has a similar side-effect profile to other oral contraceptives.'

A Colmar Brunton poll in 2000 showed that only 20% of women surveyed after being shown the advertisement for Diane-35® realised it was also a contraceptive.

A British study had shown that the risk of venous thromboembolism (VTE) with this product was more that eight times the risk of women not using contraceptive pills and double that of women using other new generation oral contraceptives. By November 2001 there had been 18 reports of VTE in New Zealand women using Diane-35®. Where the reasons for using the medication were known, ten were for contraception, five for acne and two for irregular periods.

In 2002, Medsafe wrote to all doctors asking them to review all women on this medication. By this time, 25 000 New Zealand women were using Diane-35®, or its equivalent, Estelle-35®.

This case study was first published in: Coney S. Direct-to-consumer advertising of prescription pharmaceuticals: A consumer perspective from New Zealand. *Journal of Public Policy and Marketing* 2002; **21(2):** 213–223.

The final question asked whether the responders would support a ban of DTCA in favour of a new, independent, consumer health information service. Slightly more than half said that they would. The academic group also decided to assess the level of support for their position by writing to all general practitioner colleagues in New Zealand. A letter was sent detailing the conclusions of the authors after review of the literature around the effects of DTCA and stating their intention to advocate for a ban. The letter asked GPs to fill in a questionnaire on their opinions and experiences of DTCA. It was clearly stated that their replies would be used in support of this advocacy.

Fifty per cent (n = 1611) of all New Zealand GPs responded.[11] Table 2 summarises the results. Ninety per cent of responders stated they had experienced consultations specifically generated by DTCA. Seventy-nine per cent of responders reported that patients had frequently asked for DTC-advertised medicines, with the same percentage expressing negativity towards DTCA. Only 4% of the responders believed DTCA provided the balance of information needed by consumers. In addition, several hundred responders provided a rich collection of reasoned opinion and anecdotes.

So far so good

The advertising and broadcasting industries became aware of the correspondence within days and a sustained campaign to discredit the professional reputations of the authors of the letter and their university began. This initially took the form of letters to the Dean of the Medical School of the principal author accusing the three professors of unethical behaviour and threatening to go to the press if the support survey were not stopped. When this was rebuffed, letters were sent to the local ethics committee and finally a formal complaint to the university containing several accusations of unethical and dishonest behaviour. A number of very strident accusations of unethical behaviour and of attempting to mislead general practitioners and proposing to mislead politicians were simultaneously printed in various national business and medical newspapers. Interestingly, the main thrust of the complaint seemed to centre on the allegedly unethical practice of being too honest in the covering letter. It was claimed that it was unacceptable to state the position of the authors and to signal the intent to lobby government with the opinions of those who chose to respond to the survey of support. The activity was thus clearly and explicitly advocacy. This was also clearly spelt out in the larger report to the Minister.

A professor of bioethics was appointed by Otago University to conduct a preliminary inquiry as a standard response to the formal complaint. In a 28-page in-depth analysis he identified a total of 23 elements to the complaint. All were dismissed and, further, he concluded that the complaints were vexatious.[19] A number of factual errors were also identified in the letter of complaint. Despite this, the industry-run Advertising Standards Authority has continued to try and publicly discredit the authors of the substantive report, repeating the same accusations in the press and on radio. The pharmaceutical companies have to date been relatively silent, beyond disputing some data on advertising spend quoted from a public document. Within the main report a number of case studies detail several examples of the problems of DTCA. No-one from the pharmaceutical companies could be found who was prepared to publicly debate the report with the authors on national radio.

At the time of writing most of the key medical organisations have come out publicly in support of the two recommendations of the report, as have a number of specialist groups, most publicly the academic public health community, clinical pharmacologists, respiratory physicians, and academic pharmacists. Many others are reconsidering their

	Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree	Don t know
Consultations generated by DTCA are often unnecessary	35	33	13	13	6	1
Patients frequently ask me for DTC-advertised drugs which aren t appropriate	40	39	9	8	4	0
I have felt under pressure to prescribe advertised medications	32	37	10	10	12	0
As a result of a patients request I have switched to/started medication with an advertised drug which I feel offers little benefit over treatment I d ordinarily use	14	30	15	14	28	0
In general consultations generated by DTCA lead to little health gain for patients	32	25	18	17	7	1
DTC advertising is a very useful means of educating consumers about the balance of risks and benefits for prescription medicines	3	9	9	15	63	0
In my experience consultations in which patients seek advertised medications can lead to difficulties in the doctor—patient relationship	19	31	22	15	13	1
DTC advertising currently provides the balance of information consumers need	2	2	7	15	73	1
Generally DTC adverts have helped my patients to get necessary medical care at an earlier stage	2	14	19	21	43	2
Generally DTC adverts have led to better compliance by my patients	1	12	27	18	34	8
Adverts for lifestyle drugs may encourage the medicalisation of well populations	40	34	12	6	5	2
Generally DTC advertising have improved the quality of my prescribing	1	2	13	14	69	1
Overall I feel direct-to-consumer marketing of prescription-only drugs by pharmaceutical companies is positive	3	7	10	19	60	1

Table 2: *Opinions of 1611 (>50%) of New Zealand general practitioners. GP responses as percentage.*

positions. To date, no health professional groups have opposed the proposal to ban DTCA in favour of the establishment of an independent, consumer health information service. Forging advocacy positions with these important and concerned groups is all-important for success. Several independent consumer associations have also made public statements in support of a ban. Again, to date, no independent consumer associations have opposed either of the recommendations in the report to the New Zealand Minister of Health. The report has been passed to the Ministry of Health and a statement of intent from the Minister is expected imminently.

We believe general practitioners and academics have a crucial role, and indeed a professional duty, to challenge the *status quo*, even if it means simultaneously taking on the vested interests of the powerful pharmaceutical, advertising and broadcasting industries. It is gratifying that so many other groups have now swung in behind the call for a ban on DTCA. To use the Antipodean analogy, it takes a few people prepared to stand like 'possums in the headlights' providing the initial focus (and target) to stimulate debate and prompt consumer, political, and professional groups to action. General practice and public health have always been inextricably intertwined. General practitioners are in a unique position to assess significant influences on the public health. Advocacy for individual patients is a recognised and accepted core function for general practitioners. Advocacy by general practice on matters affecting the public health at large is equally important. The more so when there seems to be a grudging acceptance of the impossibility of taking on the enormous power, resources, and influence of vested commercial interest that are driving the 'pharmaceuticalisation' of health. It is, of course, easy to see how the energy and enthusiasm to take up such causes has been sapped by an increasingly externally controlled world of guideline/standards and target-driven general practice. In New Zealand, the perception of advocacy as a core role of academics within universities to act as critic and conscience of society has diminished. Opponents of this campaign have tried to publicly discredit the authors by questioning whether it is a legitimate function of university academics and an appropriate use of taxpayers' money to advocate against practices seen as endangering the public health.

We can learn a lot from the possums downunder — neither rolling over and playing dead nor standing transfixed by the headlights are likely to result in satisfactory health outcomes. In contrast, there is clear anecdotal evidence (Grade 4-) that involvement in a worthy cause leads to significantly greater overall job satisfaction.

Les Toop
Dee Richards
Tony Dowell

References
1. Hart JT. The inverse care law. *Lancet* 1971; **1(7696):** 405-412.
2. Beale N. The nature of unemployment morbidity. 1: Recognition. *J R Coll Gen Pract* 1988; **38:** 197-199.
3. Westin S. The market is a strange creature: family medicine meeting the challenges of the changing political and socioeconomic structure. *Fam Pract* 1995; **12(4):** 394-400.
4. Minnesota Medical Association. *Pharmaceutical Issues Survey for Minnesota Physicians*. Survey Results. 2000.
5. Mansfield P. Healthy Scepticism, 2003. URL: **http://www.camtech.net.au/malam/publica1.htm**
6. Moynihan R. The making of a disease: female sexual dysfunction. *BMJ* 2003; **326:** 45-47.
7. Logan A. Time to reverse that altruism bypass. *Br J Gen Pract* 2002; **52:** 425.
8. United States General Accounting Office. *Prescription drugs. FDA oversight of direct-to-consumer advertising has limitations*. Washington DC: GAO, 2002; 1-33.
9. NIHCM Foundation. *Prescription Drugs and Mass Media Advertising, 2000*. Washington, DC: The National Institute for Health Care Management Research and Educational Foundation, 2001; 17.
10. Ministry of Health. *Summary of Submissions on the Direct-to-Consumer Advertising of Prescription Medicines in New Zealand. Discussion Paper*. Wellington: Ministry of Health, 2001.
11. Toop L, Richards D, Dowell T, *et al*. *Direct-to-consumer advertising of prescription drugs in New Zealand: for health or for profit?* Christchurch: University of Otago, 2003. URL: **http://www.chmeds.ac.nz/ report.htm**
12. Meek C. *Direct-to-consumer advertising (DCTA) of prescription medicines: a review of international policy and evidence.* London: Council of the Royal Pharmaceutical Society of Great Britain, 2001.
13. Mintzes B. *An assessment of the health system impacts of direct-to-consumer advertising of prescription medicines (DTCA). Volume II: Literature Review*. Centre for Health Services and Policy Research, University of British Columbia, 2001.
14. Mintzes B. *An assessment of the health system impacts of direct-to-consumer advertising of prescription medicines (DTCA). Volume III: Patient Information on Medicines: a comparative patient/doctor survey in Vancouver and Sacramento.* Centre for Health Services and Policy Research, University of British Columbia, 2001.
15. Mintzes B, Kazanjian A, Bassett K, Lexchin J. *An assessment of the health system impacts of direct-to-consumer advertising of prescription medicines (DTCA). Volume IV: Pills, Persuasion and Public Health Policies*. Vancouver: Centre for Health Services and Policy Research, University of British Columbia, 2001.
16. Morgan S. *An assessment of the health system impacts of direct-to-consumer advertising of prescription medicines (DTCA). Volume V: Predicting the Welfare and Cost Consequences of Direct to Consumer Prescription DrugAdvertising.* Vancouver: Centre for Health Services and Policy Research, University of British Columbia., 2001.
17. Colmar Brunton Social Research Agency. *Consumer Opinion: Prescription Medicines.* [Information prepared for Christchurch School of Medicine, New Zealand.] 2003; 12.
18. Consumers Association. *DTCA Survey Results*. London: Consumers Association Campaigns.
19. Evans D. Preliminary Inquiry into the Advertising Authority Complaint. URL: **http://www.chmeds.ac.nz/report2.htm**

The economic evolution of American health care: From Marcus Welby to managed care
David Dranove
Princeton University Press, November 2002
PB, 211 pp, £12.95, 0 69110253 8

It's coming to America first
The cradle of the best and of the worst.
It's here they've got the range
And the machinery of change …

WHAT happens next? What happens when we've all worked our socks off and we're clean out of all those billions that the Chancellor Gordon Brown gave us? What happens when the service has improved out of all recognition but the public is still dissatisfied, still believing expectations are best experienced as rights and delivered without price tags? Well, the prophets will turn once more to the West because that is where the machinery of change is roaring, like Coca Cola down a thousand throats on a hot summer night in the desert.

And what would British medicine be like if it was surfin' that West Coast dream? Well it's hard to imagine our dear old NHS, the mother of all health services, really jamming to the free market. But if we do have to get with it then this book is a groovy place to start.

Managed care is that bit of the US health system where local health care organisations buy packages of care on behalf of their enrolees from providers. The care is managed because it is the Health Maintenance Organisation (HMO) that does the buying, rather than the patient (that's fee-for-service) or the Government (that's Medicare and Medicaid). Lost you already? Well, there are enough similarities between managed care and PCTs to make the movers and shakers in the NHS happy to book lots of flights to the US to look at how some HMOs achieve better outcomes than the NHS for apparently less cost. Given that this particular bit of the US might be coming to your local health care outlet quite soon, then you may want to understand the nature of the beast. If so, this book is a great place to start.

Dranove is a health economist who has spent his life researching managed care. He writes about a dry and difficult subject with passion and understanding. To describe a book about health economics as elegant is perhaps a paradox, but this one gets close. I came away better educated about both health economics and why the US health system is headed in the direction it is.

The core problem for all health services, according to Dranove, is shopping — how do you ensure that patients or their agents 'buy' the care that is most appropriate for them? HMOs are the most successful attempt to solve this problem in the States but this is achieved by limiting patient choice. Each referral or intervention is reviewed to certify that it meets pre-agreed criteria (known as utilisation review) and every clinician's records are subject to random review by outside Professional Review Organisations (PROs), to ensure appropriate care. And since patient choice is sacrosanct in the US, HMOs are currently in decline.

In the UK, PCTs buy services on behalf of their populations. This system is bedevilled by two problems: PCTs are weak purchasers in comparison with the acute hospitals that dominate the commissioning process. And the actual shopping is done by GPs (through their referrals) in a manner so free and unregulated it would make an American physician's mouth water. Referring someone without prior review would be anathema under managed care — how can one shop rationally if the buyer's decisions are not controlled by those who pay the bills?

Is any of this relevant to you and me? Interestingly, the move to encourage PCTs to manage waiting lists has led at least two Strategic Health Authorities to propose that referrals are reviewed prior to forwarding to the hospital (sounds like utilisation review to me) and that practices with high rates of referral are independently reviewed (which is mighty similar to PRO procedures). So you see, you may need to read this book after all.

At the heart of the NHS is solidarity. You get multiple sclerosis and I bear your costs forever. My child gets leukaemia and you pick up the tab. In an increasingly fragmented world this invisible, unacknowledged risk-sharing girdles us all and is, still, a source of profound social cohesion. To the British reader the key question is whether the choice and competition so loved by Americans are useful tools that will breathe life into the more atherosclerotic parts of the NHS. Or are they the Trojan horses that will further undermine the very equality and egalitarianism on which it is based?

Of course it may be that, post-Iraq, post-Bush, the last thing we will want is more freedom. In our widening gyre away from 9/11, it may be that the rough beast of Al-Qaeda that now slouches towards Jerusalem has drowned innocence and transformed choice and complexity into vulnerability and weakness. Control and safety may be all we can afford to dream about now:

Give me back the Berlin Wall,
Give me Stalin and St Paul,
Give me Christ or give me Hiroshima.
Destroy another foetus now, we don't like children anyhow.
I've seen the future, baby: it is murder.

Either way we'll probably still meet America coming the other way.

Paul Hodgkin

1. Leonard Cohen, 'Democracy'.
2. Leonard Cohen, 'The Future'.

Getting health economics into practice
Edited by David Kernick
Radcliffe, October 2002
PB, 358pp, £29.95, 8 85775 575 8

THIS is a book which is essential reading for any GP who wants to know about health economics and its relationship to health and health services. It also covers areas that are increasingly important to GPs involved in commissioning or sitting on PCT executive boards, and those running general practice at the coal face.

As one of the few GPs that really understand this subject, Kernick has produced a *magnum opus*, which 'started off as an introductory text and got rather out of control'. He has assembled an impressive list of co-authors, such as Sir Denis Pereira Gray, Alan Maynard, Martyn Evans, and Charles Normand, who provide the text with expertise and gravitas and offer variations in perspective that fit well with each other. The result is an intelligent book on a complex subject, which is explained in simple terms. The reader is introduced to the whole vocabulary of health economics and its basic concepts. These include, for instance, the ideas of opportunity cost, cost effectiveness, marginal costs, and information asymmetry. The reader is given a thorough briefing on areas that many of us have never quite understood, such as the pharmaceutical pricing regulatory scheme.

Apart from educating us, Kernick has some powerful messages on how we should run the health service and how good intentions often have negative consequences. For instance, he discusses how performance monitoring can crowd out the intrinsic motivation of those of us working at the frontline. He tells us why, on a human level, trust is actually better than the easier option of continuously checking. He describes well the incompatible objectives of manager and clinician. Iconoclastic as ever, he disputes the view that rationing should be overt because, in reality, 'it probably never will be or should be' and GPs will always remain the ultimate rationers.

The book is a continuous attempt to merge the world of health economists with the everyday world of the NHS. Too often, it seems, health economics is fine in theory but fails in practice. His irreverence is refreshing, yet authoritative, as he speaks both as a health economics and 'hands on' GP. So the text becomes a continuous battle between the 'sunny uplands' of health economic theory and the 'swampy lowlands' of life as it is. His flirtation with complexity theory, which is well explained in one of the later chapters, might infer that the two cannot be brought together. Yet his conclusion is more optimistic that 'Health economists should work more closely with disciplines and decision makers whom they seek to influence, rather than offering prescriptions from outside the healthcare environment'. They also need to better understand the experiences of us everyday practitioners, who are wallowing in the mire.

The book is well laid out throughout and each chapter has a clear heading, executive summary, and conclusion, which makes the text pleasantly tight. It can be read from cover to cover or used as a useful reference book for subjects such as programme budgeting and marginal analysis, evaluating shifts of services from secondary to primary care, the economic evaluation of doctor/nurse skill mix, health care rationing or the relationship between health economics and complexity theory.

Like all great books, it is liberating and empowering. It challenges reductionist and linear models of economic theory with the same vehemence that Balint once liberated general practice from a literal and reductionist approach to our patients. It is empowering because if clinicians have the keys to health economics then they can become masters of their own destiny with the New NHS. If we want to have a hand in changing the NHS, local or national, then we cannot walk away from health economics, but must, as Kernick ably does, learn to control and use it and find its real place and value. Today, health economics is alien territory to most clinicians and something that is dropped on hapless practitioners by health economists. If enough of us read this book then perhaps health economics might evolve in a way that was mutually useful to practitioners and the health service — not to mention our patients.

Michael Dixon

Oxford Textbook of Medicine (4th Edition)
Edited by David A Warrell, Timothy M Cox, John D Firth and Edward J Benz Jr
Oxford University Press, February 2003
HB, 4500pp, £275, 0 19262922 0

LARGE textbooks leave the shelf mainly for four reasons — for material of general interest, for looking up rarities, for looking up topics of personal interest so as to disagree with experts, and for browsing.

This textbook begins with essays of general interest. With a show of political correctness, it starts with the patient's perspective; but the patient is a retired barrister, so the language is not so much of the last century as the one before that. Go quickly past the potted history and ethics, and things begin to look up. Excellent articles on evidence-based medicine, randomised controlled trials, alternative medicine, preventive medicine, and screening. These opening sections end with a maverick essay by a Malthusian who thinks the AIDS epidemic will 'disentrap' the lucky Africans from their population problem.

The next sections are good too, especially for those of us who need to update our knowledge of cellular mechanisms, genetics, genomics, and immunology. By now you may be wanting to take this volume to bed with you. But beware: resting any volume of the *Oxford Textbook of Medicine* on your abdomen carries a significant risk of splenic rupture. Other fields of learning divide their texts into readable volumes (compare Grove's *Dictionary of Music and Musicians*, Bean's *Trees and Shrubs*, Whiffle's *On The Pig*). But medicine believes in textbooks of mass destruction.

So let's use it as we normally do, with the book resting safely on a table, to look up things we've seldom heard of. Here the index is a help. But it can be annoying to have to hop from one bulky tome to another, without enough guidance as to what aspect is covered where. Say we have a patient newly diagnosed with antiphospholipid syndrome. Dimly aware that this is bad news, we look up the first entry. This turns out to be about subclasses of complement. There are several references in the second volume, but these are about thrombosis and pregnancy. In a section on systemic lupus erythematosus in volume 3, we find some scattered and oblique information about our syndrome, which is not only important but relatively common. We are not much the wiser but we have had a good upper-limb workout.

Browsing is more fun, offering *frissons* of amazement at your ignorance. The sections on infectious and tropical diseases are rich mines of unheard-of pathology and nomenclature. Or you can browse by looking through the index. 'Carp gallbladder, poisoning following ingestion' is my current favourite. There are the colour pictures to match, though most of the book is illustrated in black and white, and not always very well (for example the X-ray said to demonstrate osteoarthritis of the hip).

All of us think we know something about a particular area of medicine, so we will look for gaps and mistakes in what others write. Let's go to heart failure. An excellent section by Andrew Coats reads smoothly and covers the ground better than any account of comparable length that I have come across. In fact it renders the later sections on heart failure largely redundant. Now let's hop to fungus poisoning. Again, concise and excellent. Coeliac disease. Very good too, though perhaps there could have been more on the way it presents in the community. All in all, this textbook deals very well with the things it deals with.

What — am I hinting that there can be omissions in a textbook which includes an account of carp-gallbladder poisoning? I am afraid so. We have already seen how a newly defined multi-system disorder such as antiphospholipid syndrome can slip the net. In fact, ANCA-related vasculitis fares likewise, and if we look it up in the index we are curtly told to '*see* antineutrophil cytoplasmic antibodies'. The very common can get short shrift too. The most common human illness of all, coryza, does not reach the index. Then there are the usual artificial boundaries that define what is 'medicine' and what is not. Spinal cord compression is medicine, but spinal nerve entrapment is something else.

So here we have a fourth-generation dinosaur, big, shiny and the picture of health. Why isn't it extinct? I think it is because we love dinosaurs for reasons other than their ability to munch through forests of information. We keep them as pets to frighten fellow-mammals, like visiting consultants and practice inspection teams. If we wanted information, we might do better to have it on CD-ROM, or look it up using the endless resources of the Internet. But nobody stands in awe of those: they are virtually invisible. You never see an important person interviewed in front of a little CD rack rather than an enormous collection of books. The *Oxford Textbook of Medicine*'s publishers seem to know this and have not produced a CD-ROM to coincide with this edition. It may appear later.

Richard Lehman

Doctors and patients: an anthology
Edited by **Cecil Helman**
Radcliffe Medical Press, 2002
PB, 176pp, £19.95, 1 85775993 1

CECIL Helman's edited anthology of stories is quite simply an inspired book. The collection is creative in the collation of texts and it is bound together with an expertise which is assured and authoritative.

Doctors and patients: an anthology is divided into three sections. The introduction states the aims, to explore the 'two distinct but interrelated worlds [of patient and doctor] and how they interact with one another at times of human suffering'. It is also about how differently these interactions are experienced, depending on who you are. Thus there are stories that are challenging and thought-provoking (for example, Sinclair's *My life as a pig*), while others are harrowing (such as William Carlos Williams' *The use of force*).

Certain themes are clear — medicine and machines, nature and time, and patients versus people — just a few of the subjects that are so handsomely illustrated by these stories. Part of their joy comes from their diversity: my particular favourites are *Sanatorium* (William Somerset Maugham), *Observer Life* (Ruth Picardie), *The case of David Murray* (A J Cronin) and *Rebecca* by Oliver Sacks. The last example is a beautifully written piece about the need to 'neurologise' a 19-year-old girl with autism; in so doing her 'own personhood' becomes lost, almost irretrievably. The pieces on tuberculosis are fascinating — TB as harbinger of death, the enforced isolation, and the therapies designed to counteract its multiple effects — all feature, as if to remind us that this is one condition that shouldn't be forgotten.

Other authors include Anton Chekhov and Franz Kafka, while Helman's worldly colleagues, such as Moacyr Scliar (who wrote a lovely short story set in Brazil called *The King of Xingu*) also contribute to the anthology.

Who is the book for? The back cover gives us a clue: those interested in doctor–patient communication, the medical humanities or the literature of medicine. In many ways this is far too narrow. I think this book should be included in the 'essential reading list' of appropriate modern day medical undergraduate courses as a means of enhancing compassion, empathy, and good communication when it comes to patients and colleagues. Since we are about to launch a new BSc in the Medical Humanities at University College London, this book will undoubtedly play a part, and let's hope the students enjoy it as much as I did.

Surinder Singh

roger neighbour *behind the lines*

On heroes

ONE of the weekend papers has a regular column where a C-list celebrity is asked a formulaic series of personal questions, and answers them in terms calculated to give the illusion of frankness. 'What's your greatest fear?, 'Which living person apart from Margaret Thatcher do you most despise?', that sort of thing. I confess — but I bet you do it too — sometimes it's fun to imagine one's own replies, witty and evasive for the most part, but with occasional glimpses of the lovable sage we all know we are at heart. 'How often do you have sex?' (When I remember.) 'Do you believe in life after death?' (I'll let you know.)

There's always one question I have no difficulty with: 'Which historical figure do you most admire?' Easy, no doubt about it — Schubert. To me, the composer Franz Schubert is the patron saint of the little guy. Small in stature, colossal in creative legacy, loyal to and cherished by his many intimate friends, Schubert could be alone in the midst of a crowd, his imagination constantly translating the human predicament in all its poignancy into musical form. Someone wrote, '… whereas with Mozart at his best we scale the heights and come down again, when Schubert is at his best we can plumb the soul's absolute depths and come up again.' What a great doctor Schubert would have made; yet, arguably, how impoverished would have been posterity had he devoted himself to the merely corporeal instead of the sublime.

Heroes have the ability to induce improvement at a distance, to enrich (often unwittingly) admirers remote in time and place, to teach without teaching. Heroism is out of fashion nowadays, when everything may be put into league tables except the things that matter. But I think it's OK to have heroes, as long as the hero has merit as well as talent. Ah, but how are we to determine merit, especially if the hero-designate is long dead? Legions of could-have-been should-have-been heroes have passed unacknowledged into history, solely because we fail to spot the equivalences between their times and ours, between the adversities they transcended and those we wrongly believe to be uniquely our own.

Let me now make the case for dumpy, myopic little Schubert. That his talent was prodigious we'll take as read. But merit? You'd think that — middle-class, secure, miffed but not devastated at the modesty of his reputation — Schubert experienced little adversity against which to test his potential as a hero. (Except the syphilis that killed him at 31, of course, which frankly he didn't handle well; fancy swallowing all that mercury without checking the side effects.)

When Schubert began writing songs in the early 1800s, they were expected to conform to a 'strophic' structure: each verse written to pretty much the same music, each verse closing with a pretty cadence. Hardly surprising: Schubert's Vienna was itself a conformist and rigidly structured city. But, behind its chocolate box façade, Vienna was in fact a police state, permeated by spies and corruption, presided over by the Blairite Prince Metternich and his henchman, the Alistair Campbell-like Chief of Police, Josef Sedlnitzky. Schubert's friend Bauernfeld wrote of a regime that 'weighed on us all like a monkey we could not get off our back'. Martha Wilmot complained that 'we never cough nor wipe a child's nose without the event being reported to Government'. Individuality was dangerous. Safety lay in a public show of smiling acquiescence, following the guidelines, staying (as we should now say) 'on-message'.

Encouraged perhaps by braver friends, Schubert made a small but crucial change to musical convention. He began to write some songs *durchkomponiert* — 'through-composed'. Rather than being compartmentalised into repetitious verses, the text was set to a single over-arching and coherent plan, freely but faithfully following the logic and mood of the words. The big picture became more important than its component parts. By his own lights, Schubert's innovation was subversive, seditious — but (as the triumph of imagination over regulation) oh! how liberating.

My point? Our national life and institutions are strophically constrained to the tune of our five-year electoral cycle. Every five years the NHS has to be made to look neat, to sound pretty, to act obedient. Government, for fear of short-term unpopularity, dare not think the big picture that the complexity of healthcare requires. So — since we are middle class, secure and miffed at the modesty of our reputation — we must encourage it. Social policy needs to be more *durchkomponiert*. Sorry about the ugliness of the phrase, but Schubert can teach us anti-compartmentalism. And for that he is a hero.

Further reading

Neighbour R. The Doppelgänger Revealed? In Newbould B (ed). *Schubert the Progressive: history, performance, practice, analysis*. Aldershot: Ashgate Publishing Limited, 2003; 139-149.

(Forgive the plug, but I'm inordinately proud of having some wacky ideas about the origins of Schubert's creativity — that he may have been the singleton survivor of a twin pregnancy — taken half-seriously by musicians and musicologists, to whose professional world I'm a deferential visitor.)

The Last Diaries: in and out of the wilderness
Alan Clark
Weidenfield and Nicolson, London, 2002
HB, 386pp, £20, 0297607146

So the first question is whether Alan Clark is interesting in spite of his flaws, or because of them? Easy. After all, if it were not for his faults he might be Stephen Dorrell.

Only this can explain how a man who referred to his wife as 'beloved little Jane', who believed that the problems of Northern Ireland would be helped by the British Army rounding up and killing 600 people, who described the Serbs in heroic terms and who congratulated his priest on conducting a Christmas service without 'any mention of the need to "combat" racism, homelessness or poverty or any of that crap' could be lionised as a great diarist — even the 'greatest diarist'. God help us, here is a man who kept a picture of Adolf Hitler ('Wolf'), described in tones of admiration at all times — on his wall.

And yet. No book has caused me to irritate my wife quite so much by the compulsive desire to read aloud sections of it. By contrast, Jeremy Paxman's excellent *The Political Animal* passed in relative silence. Certainly, if Paxman has wished for an accompanying book to demonstrate how vain, arrogant, over-confident and under-qualified politicians are, he could have hoped for none better. Similarly, the politicians' public schoolboy obsession with the snakes and ladders of politics to the eclipse of policy, is amply illuminated.

And yet. Here is a man who is lionised wherever he goes by people from all sections of society. Women make passes at him even as he is fading away, louts cross the road to shake his hand. And yes, naturally some of this is because his causes are too often the easy misogynist, racist causes beloved of the taxi-driver mentality, but there is undeniably something else.

He is unshakeable in his convictions: animal welfare, religion, this 'great country'. He is flamboyantly sexual. He is transparently transparent. In an age where politicians have become at best 'long-stop' social workers, at worst followers of the dreaded focus group, he leads from the front, jaw first. He makes glorious (and inglorious) mistakes. He is human.

Sometimes the humanity is floridly overplayed — whether his bowel actions require recording in such minute detail I personally doubt. (The book begins with a glossary of Clark-slang, of which the terms 'Thompson' and 'Plopson', both meaning to defecate, are both the most graphic and the most utilised) Similarly, his erections and their lack are chronicled, as are his marital couplings.

My first draft of this review was written after about 100 pages. I was irritated by his obsession with 'X', a mysterious lover. At that point I would gladly have supported Jane in pressing the pillow over his face. By the end, as he had stared into death's abyss, lonely and scared, when I had read Jane's moving account of his descent into coma and death, I was nearly in tears, and a re-write was underway.

This being a medical journal, and Clark having recorded his symptoms and consultations with sometimes tedious thoroughness, the reader might expect some comment. Sadly, this reviewer found this the least interesting element of the book, and paused only briefly to remind himself how difficult being a doctor is when we are offered such a small sub-section of symptology (and yet so much white noise). Discreditably I could also not fail to notice how much easier it was for Mr Clark to get in touch with Nick Thomas, his neurosurgeon, than I have found it on a number of recent occasions.

Some would argue that, if we are at a point where a man such as this was being seriously considered for high office, then we are in a bad way. But we are also close to a point where but a narrow view of the world is tolerated, which in itself must be dangerous. Taking Margaret Thatcher's cue, Tony Blair and New Labour have frequently characterised those who disagree with them as being off-limits or even traitorous. Perhaps we still need our firebrands. As his medical notes undoubtedly say, RIP.

David Tovey

wendy-jane walton

At this time of year the roads are peppered with runners. Barely a month to go until 'The Marathon', as it is known among non-running circles, or 'London' in regular running parlance. So my patients are asking more and more frequently 'Are you running the marathon this year?', while my running friends enquire 'Are you doing London?'. For of course, while there are many races over 26 miles and other distances taking place year round, all over the country and beyond, the one that matters to the Great British Public is London, and it is the benchmark of all other running achievement. We have learned this week of the death of Chris Brasher, founder of the event 22 years ago, and himself a great athlete, who had paced Roger Bannister to his record breaking four-minute mile in 1954. His absence from this year's event will be a source of sadness to the 30 000 runners who line up at the three starts in Greenwich Park and Blackheath on 13 April.

I shall not be among them, though I can be guaranteed to be glued to the TV and sharing vicariously in the joy and the pain of those 26 miles, over a course that I have covered five times. There is something about running that appeals to even the most sedentary of human beings. It is my one characteristic that my patients invariably admire and enquire about — and I am more than happy to share my enthusiasm, to give advice to beginners, and to encourage those who are keen to take it up. My running companions in the club are, conversely, not in the least impressed with the fact that I'm a runner, since they share this attribute, but are amused and interested by the fact that I am a doctor. I endeavour whenever possible not to mix work and pleasure but it is impossible not to get drawn into other peoples' problems, large and small, especially since a substantial proportion of the club membership are my registered patients. It is rare that I escape the odd little consultation about injury on training nights, and I remember one particular evening when, during the course of an hour's run, I conducted on-the-hoof consultations in obstetrics, orthopaedics, general medicine, cardiology, psychiatry and gastroenterology. Marathon training is conducted at conversational pace, so this is not as unlikely as it sounds. Training in company makes the time pass quicker and the friendliness and support among the running fraternity is of almost as much benefit to some people as the physical exercise itself. There are times — most of the time, for me — when a solitary run on the hills is actually more attractive, but there is always a warm welcome at the club.

So as the Marathon approaches and I see folk out training I can recognise a large proportion of the people I pass in the car by their running style, and give them an encouraging toot as we pass. They recognise my car and give a friendly wave in return. But on Monday 14 April things will look different. There will be runners on the street, but to those of us who know, they will look different. These are not the familiar figures of the well trained, nor of the footsore and weary, who are sensibly resting after the previous day's outing. These are a new band, a little tentative perhaps, just out for a little jog, a short distance to try it out, inspired by the efforts of the masses thronging London's streets the day before.

Some of them will fall by the wayside, but a few will keep it up, and join a training club, or find companions to run with, and in a year or two's time they too may be among the enthusiasts, hammering out the miles through the winter and early spring months, in order to share in the heart-thumping anticipation of standing on the start line in a chilly April morning, and crossing the finish in the Mall a number of hours later, exhausted and elated.

There's nothing to beat it.

The BMJ, in signalling that a paper has been fast-tracked, uses the somewhat strange motif of a spindly Edwardian bicycle. If, at the *BJGP*, we ever get round to fast-tracking anything, we'll be using an altogether more dynamic image, demostrated here by Professor Tony Dowell, Head of the Department of General Practice at the University of Otago in Wellington, New Zealand. He fell off a moment later, by all accounts...

neville goodman

Patients know

Back pain is impossible to imagine if you've never suffered it. When a colleague disappears for a day or two, leaving you with their work to cover, then returns clutching their lower back occasionally, anyone who has never themselves suffered will think they've been on a bender, or been taking time out to repoint the shower room.

I'm sure the actual pain of a myocardial infarction is worse than one's imaginings, but we've seen the vomiting and the sweating. We've taken ECGs and measured troponins. A 'banged funny bone' is bad enough, so it's not difficult to imagine the pain of sciatica. But lower back pain has nothing to show for it. There's nothing to measure. From the outside there's nothing to feel.

I've had back pain, so I know. The first time, which was 20 years ago, I deserved it. I was pruning a rose bush (too early, unfortunately, as it was then killed by an unexpectedly late but hard frost). There was an errant shoot just a little bit further in — and it was three days before I could stand up straight again. The last time, which shows the effect of 20 years on connective tissue, I was merely getting out of bed. I grimaced my way through the day but then made the mistake of carrying my brief case to the car. Halfway there, an agonising spasm gripped me. I could drive only with maximally forced extension of my arms, and taking one hand off the wheel to change gear brought tears to my eyes. Next morning, my wife sensibly suggested that, as it had taken me five minutes to get out of bed and I was physically unable to brush my teeth, I was unsafe to give anaesthetics.

Knowing that one shouldn't take to one's bed, and that gentle exercise is good, I walked to the shops in the afternoon. Every 10 metres or so I had to stop and place both hands firmly into the small of my back. Otherwise my abdominal muscles tensed so much that I could barely breathe. As I ascended the steps to the post office, I was elbowed aside by sprightly folk anxious to collect their pensions.

The following week, I saw the colleague who had covered for me. When she had seen the first patient on the operating list and explained that the anaesthetist who had visited the night before had gone off sick, the patient said, 'I'm not surprised; he looked terrible!'

Patient-centred medicine can't come fast enough.

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james willis

What is it about New Zealanders?

'More national service frameworks are promised. All converge at the generalist primary care team and compete for scarce time. Those seeking accountability from the health service should acknowledge the workload, morale, and opportunity costs of their targets and timeframes. NSF — 'not so fast', perhaps?'[1]

WHAT is it about New Zealanders? Even when the landlocked but money-drowned Swiss have bought their best America's Cup crewmen, they still have enough left in their tiny population to come in as runners-up in the most hotly-contended competition in world sailing. And when it comes to their general practice community, for sheer common sense and clarity of thought on crucial contemporary issues, this tiny group doesn't so much 'punch above its weight' as reach right around the globe to knock our coagulated Babel of self-satisfied talking shops squarely on its introspective and self-interested chin.

Naturally, I follow this assertion with the evidence upon which it is based.

Les Toop and Dee Richards, of the Department of General Practice in Christchurch, New Zealand, wrote what should have been the definitive commentary on the practical implications of National Service Frameworks in their *BMJ* editorial, the concluding words of which I quote above. It was called 'Preventing cardiovascular disease in primary care' and the *BMJ*'s neat one-phrase encapsulation ran, 'Targets are fine in principle, but unrealistic.' The article produced immediate whoops of joy up and down this land and a flurry of excited emails, of which I received a share. But like so much else that is written which is good, it didn't say what was currently fashionable and nothing at all that the government (or those who wished to remain in government employment) wanted to hear. So in spite of its devastating logic, the editorial floated off without lifeline, whistle, belt or flare into the limitless ocean, and as despairing friends called after it, was lost to view and presumed drowned. NSF's rolled on, just as it had warned, like an impenetrable fog, and doctors closed their useless eyes and threw the autopilot switch to 'on'.

We flew into Christchurch wearing the travel socks which Les Toop had told us we should wear. On 5 November — late in spring in New Zealand. That evening we were stuck for two hours in a gridlock as we returned by bus from a firework display on the coast. As they say, more English than the English.

The next day, the whole department of General Practice had given up their morning to making me welcome, showing me round and discussing matters of mutual interest. It's amazing what you get for e-mailing to say you like a paper and you happen to be passing. And the evening after that, Les's wife picked us both up and took us to their home, where their family and, again, most of the department, were assembled for a wonderful meal she had cooked. What a privilege. But quite a lot less English, in fact, than the English.

The difference is extraordinary, and it is impossible to pin down or to describe. It isn't just the clear air, blowing from the vast expanses of the Southern Ocean. It isn't just the space, and the room to grow. It isn't just the wilderness, the great areas virtually untouched by man which have now formed the backdrop to the film version of Tolkien's great saga, *The Lord of the Rings*. But something about that so-similar but so-different land allows people to be confident in themselves, and to see things with a clarity we have lost. Les Toop and the convocation of New Zealander Professors of General Practice he has co-ordinated have now produced another definitive document, arguing that there is only one proper response to the notion of direct advertising of prescription drugs to patients; simply saying no. No equivocation, no rules, no frameworks, no pandering to the big battalions or the self-interest groups — it is wrong and it must go. In the case of Britain, it must never come.

If only our profession had got together and had the courage to back the logic of what Les and Dee were saying about National Service Frameworks in 2001. If only we too had just said 'no' with our combined authority and with a single voice. Their suggestion that NSF should mean 'not so fast' has not been entertained; things have just got faster. We now have 1.17 managers per hospital bed, checking it all. And things are going to go on getting faster until either we do say stop or something breaks.

Reference
1. Toop L, Richards D. Preventing cardiovascular disease in primary care. [Editorial] *BMJ* 2001; **323:** 246-247.