Academic ability can be a proxy for a lack of social skills and dullness

Des Spence, p 49

PERSONAL VIEW **Katy Gardner**

Tendering out general practice is bad for us all

I have been a general practitioner (GP) for 34 years, and I was a GP principal long ago. In 1998, while working in an inner city practice in Toxteth, Liverpool, my colleagues and I were finding it increasingly difficult to recruit GPs, and we decided to become a pilot salaried practice. We were a group of dedicated and enthusiastic GPs but did not excel at business and were not always comfortable with our independent contractor status. Initially, we chose to be employed by our local community mental health organisation, North Mersey Community NHS Trust. Immediately we could attract high quality salaried GPs who wished to work in the inner city, who recognised that providing a high quality service in a deprived diverse area did not always attract money through the general medical services contract, and who were keen to be part of an exciting new way of working.

Fourteen years on, were we right? Over the past six months, I have experienced the full downside of this decision. I have been "out to tender" and have suffered lowered motivation, and felt powerless and angry. I am contemplating retirement, although at the age of 62 I have plenty of energy and a son at university to support.

How did this happen? Our employment evolved to Liverpool Primary Care Trust and finally, with the recent separation of commissioners and providers, to Liverpool Community Health NHS Trust, which was originally the provider arm of the primary care trust. Over time we experienced the tensions of being part of a large organisation and a considerable loss of autonomy, and sadly many of my colleagues found this hard and left.

Six months ago our trust announced that medical services practices in Liverpool should be tendered out, meaning that organisations including private companies were invited to bid to provide these services. Our premises had a problem with an unpleasant smell, and we were ready to move into new premises about a month after the announcement. Then our move dropped off the radar. All thoughts of developing as a practice halted, and plans to streamline the management of practices were put on hold.

Staff were told that we must not discuss any confidential information with anyone, creating a climate of anxiety. We were not consulted on our wishes about our future employer, and our patients were not consulted, because the trust said that there would be no material change in service provision. So why, then, is this process necessary at all?

We were told initially that the results of the tendering process would be announced in November, then December, and then January. But at the end of January we were told that the process had been abandoned. We do not know exactly why. Over the past six months I have tried to put on a brave face every day in my practice. I have focused on positive developments, achieving high clinical scores in the quality and outcomes framework, effective neighbourhood working, and excellent patient care, while trying to ignore the uncertainty. This period has been stressful for most of the staff. Colleagues have told me how morale has suffered in other salaried practices being put out to tender. Would we be employed by a private company, by a local hospital, or by another practice? What happens after rules governing transfer of employment (TUPE) expire after a year? And how can we maintain morale if we have to go through this process again? The bidding process takes huge amounts of time, public money, and energy. Many NHS employees do not fully understand the system, have little idea about tendering and competition law, and do not understand how all this can have been taking place before the NHS Health and Social Care Bill had even become law. I have heard that practices are to be tendered out again this summer, with the result announced by January and the new contract awarded in April 2013.

Our patients were not consulted . . . because the trust said that there would be no material change in service provision. So why, then, is this process necessary at all?

ROB WHITE

As a salaried GP I have enjoyed not having to manage the practice's detailed accounts and business but have found difficult the burden of micromanagement, and often feeling like a cog in a machine instead of the thoughtful enthusiastic person that I am.

As the number of salaried GPs increases we must remember the accompanying loss of control. My experience of being out to tender may be at the extreme but it may be a taste of things to come for many NHS employees. There have been several high profile cases of primary care tendering in the medical press, a process started some years ago by the Labour government. How many more such cases will we see in the next few years, as the government unrolls the NHS reforms and competition law takes hold?

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REVIEW OF THE WEEK

Can incarceration be thought of as disease?

It's fashionable to treat social problems as if they were diseases. **Stephen Ginn** reflects on a book that considers an epidemiological solution to the huge and rapidly rising prison population in the United States

A Plague of Prisons

By Ernest Drucker

The New Press; £20; 272 pages

ISBN 978-1595584977

Rating: ★★★☆

Among its many marvels, some things about the United States of America are stubbornly unfathomable. The persistent, widespread opposition to socialised medicine is one of them. And despite a murder rate impressive for all the wrong reasons, US gun laws remain unreformed.

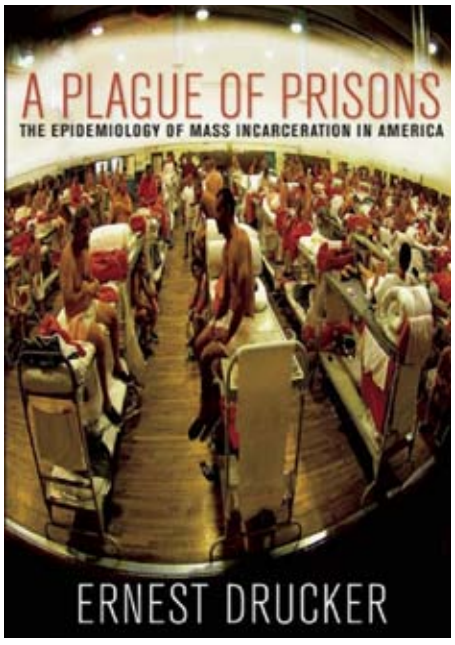
Add to this America's prisons. This is not an area in which the United Kingdom basks in glory, but the American dedication to incarcerating its citizens remains without rival. "If this population had their own city, it would be the second largest in the country," dryly remarks author Ernest Drucker.

The numbers tell the story: of a population of 310 million, 7.3 million people are under the control of the US criminal justice system. Of these, 2.3 million are imprisoned, 800 000 are on parole, and 4.2 million are on probation. The US has 5% of the world's people but 25% of its prisoners. This section of the US population grew fivefold between 1970 and 2009.

Drucker, an epidemiologist, sees this increase as a plague and amenable to examination using the tools of his trade. Although imprisonment is not usually considered a disease, this framing isn't meant to be metaphorical. The American fondness for imprisoning its citizens meets all the key criteria for an epidemic: its growth rate is rapid, its scale large, and it shows self sustaining properties.

During London's 1854 outbreak of cholera, John Snow's insight famously led to the removal of the handle of the Broad Street water pump. Soho's residents could no longer drink its contaminated water. What is the pump filling America's prisons, and is it possible for the handle to be removed? Drucker shows how in one state—New York—the rate of incarceration clearly surged from the 1970s. This coincides with the introduction of the state's so called

Bringing epidemiological theory to bear on the problem of prisons reframes that problem as something dispassionate and treatable, when in fact it is intensely political



Rockefeller drug laws: punitive legislation introduced in response to a rise in heroin use in the 1960s. These laws made it possible for those caught in possession of even small amounts of illegal drugs to receive the same sentences as imposed for violent crime. Similar legislation would be enacted throughout the country.

Most of New York City's prison population comes from just six neighbourhoods. This echoes the distribution of deaths on the *Titanic*, which reveal the rigid social structure of the Edwardian era. On the *Titanic*, those in the highest social class were more than twice as likely to survive as those in the lowest social class. In New York some areas are plunged into near anarchy by the so called war on drugs being waged on their streets, while others are almost untouched.

Incarceration also causes disability, just like disease, and is passed on to future generations, just like disease. The children of families where a member is incarcerated have a lower life expectancy and are six to seven times more likely to go to prison themselves.

The notion of applying an analysis to social problems that is more conventionally used to understand disease has gained recent cultural currency. *The Interrupters*, a 2011 feature length documentary, focused on CeaseFire, a Chicago antiviolence programme that deploys street workers as mediators between factions during incipient street conflict. It was founded by Gary Slutkin, another US epidemiologist, who considers violence to be primarily a public health issue. Slutkin has publicly encouraged David Cameron to adopt CeaseFire's approach in London.

Something must be done about prisons, but is this the way ahead? Labelling people as victims of a plague has never been a good way to rehabilitate them back into society. No matter how neatly it may fit a disease model, bringing epidemiological theory to bear on the problem of prisons reframes that problem as something dispassionate and treatable, when in fact it is intensely political. Drug laws may be America's prison pump but behind those laws lies the willingness of lawmakers and politicians to treat marginalised groups and their problems within a punitive criminal justice framework. If drug laws are reformed then opprobrium for other misdemeanours may take their place. Some US schools now use police to enforce school discipline, for example, and increasing numbers of children are being convicted via this route.

This criticism is unacknowledged by Drucker, but to his credit, the public health response he offers to high levels of incarceration is more radical than might be expected. It's no surprise that he writes that, as primary prevention, drug laws like the Rockefeller laws have to go. Secondary prevention involves prison reform. But as tertiary prevention, and to address the "great task of healing to be done on both sides of crime and punishment," he proposes a programme of restorative justice in a shape of a formal peace process, not unlike South Africa's Truth and Reconciliation Commission.

In a time when public inquiries are not in short supply, it's easy to be cynical about such a suggestion, as it is about Drucker's approach in general. But this book is accessible and persuasive. Prisons on both sides of the Atlantic represent an immense waste of human potential and financial resources. The questions of what to do about them need to be asked more often. This analysis has much relevance beyond US borders; British incarceration rates are lower, but the UK has one of the highest rates of imprisonment in Europe. Successive recent governments have presided over a steadily increasing UK prison population that has doubled in 20 years.

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BETWEEN THE LINES **Theodore Dalrymple**

For a few dollars more

We are inclined to suppose that our contemporary problems and discontents are entirely new and unprecedented, but when we look into the records we come to precisely the opposite, and no doubt equally unwarranted, conclusion: that there is nothing new under the sun.

Malpractice suits, for example, are not new. In 1870 the man who was to become the first professor of orthopaedic surgery in the United States, Lewis A Sayre (1820-1900), was sued by the parents of Margaret Walsh, a little girl on whom he operated in 1868. He published at his own expense the proceedings of the trial, which vindicated him, under the title *The Alleged Malpractice Suit of Walsh v Sayre*.

The little girl aged 6 was brought to him by her mother with something wrong with her hip. He diagnosed an abscess, inserted a trocar and cannula, and then opened the abscess with a scalpel, whereupon about of pint of pus spurted out to a distance of two feet (60 cm). He then poured some carbolic into the wound, whereupon the child cried out; the mother, alarmed, snatched the child up and ran out with her. She did not return for follow-up, as Dr Sayre suggested, and sued him instead. She alleged that she had brought the child only for examination, not operation, and that the operation had in any case been negligently performed, allegedly opening the capsule of the joint and causing the child permanent damage.

There was intrigue behind the suit. The doctor who suggested in the first place that she take her daughter to Dr Sayre, a Dr Amariah B Vaughan, also suggested that she sue him afterwards. Sayre had operated on Mr Walsh, Margaret's father, who owed Sayre $100 (a considerable sum in those days) for the operation, which Walsh had given Vaughan but which Vaughan had failed to pass on to Sayre. This was a way for Vaughan to hang on to his $100.

Sayre: sued for surgery

"It has always appeared to me that a lawyer who will permit himself to bring suit for malpractice against an honorable medical man . . . must be essentially a base, unprincipled man"

Vaughan was one of the witnesses for the plaintiff; it was he who said that Sayre had incised the capsule of the joint. Under cross examination, however, Vaughan was an unimpressive figure to say the least: not only was he a recently reformed drinker, but he had no medical qualifications whatsoever and refused to answer questions about his education (or lack of it). He had been the clerk at various druggists' stores, and he claimed to have read some medical textbooks—that was all. Of the anatomy of the hip he was shown to know absolutely nothing, explaining his ignorance by saying in the witness box that he was feeling too unwell to answer such questions.

Samuel Gross, professor of surgery at the Jefferson Medical College and the subject of Thomas Eakins's great painting of Gross operating, *The Gross Clinic*, wrote a congratulatory preface to Sayre's transcript of the trial: "I sincerely congratulate you upon the successful issue of the villainous suit against you for alleged malpractice. A few more such verdicts will go far in putting a stop to such outrageous and unjustified prosecutions."

Alas, history has decreed otherwise, and Samuel Gross unwittingly hinted at the reason why: "It has always appeared to me that a lawyer who will permit himself to bring suit for malpractice against an honorable medical man . . . must be essentially a base, unprincipled man."

But: "Some members of the American bar are, unfortunately, too prone, for the sake of a paltry fee, to encourage and engage in such prosecutions."

I am glad to say, however, that not everything has remained the same: the fees are no longer paltry.

Theodore Dalrymple is a writer and retired doctor

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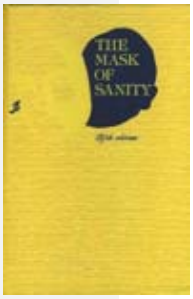
MEDICAL CLASSICS

The Mask of Sanity

A book by Hervey Milton Cleckley; first published 1941



It would be an understatement to say that *The Mask of Sanity* is one of the most important books in the discipline of psychopathy. This book not only inspired clinicians, but provided momentum for research into people whom before its publication had mostly been neglected by researchers.

The public is fascinated by so called psychopaths; a quick peek at the bestseller list will attest to this. Yet this book is much more entertaining than these novels of murder and mayhem. In addition, readers benefit from the clinical observations of one of the foremost psychiatrists of his time.

The author, Hervey Milton Cleckley (1903-1984), first published his magnum opus in 1941 while working as chief of psychiatry at the University Hospital, Augusta, Georgia. A Rhodes scholar in 1924 and later a professor of psychiatry at the medical college of Georgia, Cleckley's other notable book was *The Three Faces of Eve*, which was made into a Hollywood film.

But it was *The Mask of Sanity* that made the most significant contribution to science. In popular imagination people with psychopathy are murderers who kill and torture their victims in the most gruesome manner. But Cleckley observed that people with psychopathy can function without any obvious criminality and partial manifestations of their symptoms can be seen in people from all walks of life, including respectable professionals such as doctors, scientists, and business people.

Descriptions of psychopathy can be found dating back to ancient times. However, the present day concept of psychopathy started taking shape with Philippe Pinel's description of *manie sans délire* (insanity without delirium) in 1801. Throughout the 19th and early 20th centuries researchers' attempts to describe isolated elements of the disorder resulted in vague diagnostic boundaries.

Cleckley refined the diagnostic criteria and proposed 21 distinguishing features, which he called a clinical profile. He developed and amended these criteria in the five editions of the book published during his lifetime. Many of the criteria proposed by Cleckley survive in the present day psychopathy construct, such as Robert D Hare's *Psychopathy Checklist*, but the strength of the book remains the clinical case studies.

By identifying full and partial manifestations of psychopathy, Cleckley alluded to the dimensional nature of the disorder, which he never fully appreciated. Indeed, one of the most common criticisms of *The Mask of Sanity* is Cleckley's inadequate conceptualisation of the disorder. However, one must remember that Cleckley's primary objective was not to provide diagnostic criteria for research but to help clinicians to make sense of the people who are encountered in day to day clinical practice. Ultimately, this book's enduring appeal lies in the acute clinical observations that remain vivid more than 70 years since its first publication.

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FROM THE FRONTLINE **Des Spence**

All applicants to medical school should be interviewed

I manipulate online self testing questionnaires for attention deficit hyperactivity disorder, bipolar 2, oppositional defiant disorder, and the rest. I guess the answers to get my diagnosis. I have never failed yet. Likewise, I pore over the Diagnostic and Statistical Manual (DSM) definitions of personality disorders—narcissistic, antisocial, histrionic, and paranoid—recognising all these traits in myself. Obviously these are to be expected in a columnist. These psychological and psychiatric descriptions are interesting and to some extent useful, but are in reality just inadequate cardboard cut-out caricatures, failing to encapsulate even a fraction of any individual. Defining human personality was once the responsibility of literature. In which case, the impossibly long DSM, with its unconvincing characterisation, lack of plot, pace, and action, surely is one of the worst novels ever written. No match for the free flowing insights on humanity offered by Shakespeare.

Mere education is no preparation for medicine; worse, academic ability can be a proxy for a lack of social skills and dullness

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Increasingly, however, medical schools are using psychometric modelling and questionnaires in screening applicants, in addition to triple A academic rating. These test the soft skills of emotional quotient (EQ). A number crunched from an ability to read emotions, agreeableness, openness, extraversion, self awareness, and ability to cope—skills that blunt, direct, robust, older generations of doctors might describe as drug induced hippy 1970s nonsense. But these are real skills; evolutional tools that allowed disparate human tribes to live and work together. And mere education is no preparation for medicine; worse, academic ability can be a proxy for a lack of social skills and dullness. In the real world EQ is as every bit important as IQ. But should we rely on these questionnaires? Applicants would have to have the emotional and cognitive ability of a kitchen table not to see the patterns and loading in these questions. Test results are a guide but can easily be falsified. Especially by the adept middle class who specialise in playing any new testing game.

A few medical schools, however, rely only on these tick box tests, qualifications, and personal statements in selection. There is no interview. This is a bad idea. No employer would appoint a senior person without an interview. Interviews expose the dissonance between a sparkling résumé and the person; seeing is truly believing. And EQ is a two way street: the interviewers get an opportunity to read the candidate to see if they are genuine and plausible. Some universities use standardised structured multiple mini interviews in the name of fairness and consistency. But there is still a role for traditional, left field, free flowing interviews. This allows candidates an opportunity to shine.

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DRUG TALES AND OTHER STORIES **Robin Ferner**

Consequences

Gavrilo Princip's assassination of Archduke Franz Ferdinand in Sarajevo in 1914 led to the first world war, the deaths of 15 million people, and the Venereal Disease Act 1917. It was also indirectly responsible for the thalidomide disaster that maimed several thousand British children between 1958 and 1961.

War was announced on the day the Select Committee on Patent Medicines, set up in 1912, published its findings in its 1914 report: "For all practical purposes British law is powerless to prevent any person from procuring any drug or making any mixture, whether potent or without any therapeutic activity whatever (so long as it does not contain a scheduled poison), advertising it in any decent terms as a cure for any disease or ailment, recommending it by bogus testimonials . . . and selling it . . . for any price he can persuade a credulous public to pay."

These findings were lost in the maelstrom of war. The BMA had campaigned for the 1912 inquiry and was a powerful opponent of so called secret remedies—that is, what were known as patent cures, the constituents of which were kept secret. The BMA analysed many of these nostrums, from Absorbit Reducing Paste to Zox, and in 1909 published *Secret Remedies: What They Cost and What They Contain*—mainly beeswax and lard in Absorbit, and acetanilide in Zox (*BMJ* 2009;338:b1624). As the introduction to *More Secret Remedies* (1912) stated, the publication of the results of these analyses "has perhaps done more than anything else to open the eyes . . . to the true facts in regard to the nature of [patent medicines]."

"British law [in 1914] is powerless to prevent any person from procuring any drug or making any mixture . . . and selling it"

Ike Iheanacho is away.

Protection from untested medicines had to await the thalidomide disaster and its sequel, the Medicines Act 1968, which stipulates that those making medicinal claims for a product had to show it to be safe, efficacious, and of good quality. The act does not cover medical devices such as breast implants. Perhaps it should. The 1912 select committee described the case of "the American Macaura. He is stated by one witness to have gained £60 000 by his recent campaign in England of advertising, exhibiting and selling an alleged vibratory cure for many ailments, whereas for the same procedure in Paris he has just been sentenced to three years' imprisonment and a fine of £120." Some things never change.

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