ability to decide the sex of one's children, the availability of effective pheromones, or the manipulation of internal states by pheromones taken by mouth (to name but three) all raise horrendous practical and ethical issues. More importantly, with each of these a whole part of our reality which we take for granted suddenly rears up and becomes problematic. Biological gender becomes a "choice," the authenticity of new friendships questionable, and ecstasy can apparently be reduced to biochemistry.

So why do I sit here with all my 30 odd years grouchy complaining that things ain't gonna be what they were now? Is it a failure of nerve? An inability to look the future in the eye and accept it? Or a facile and self fulfilling acceptance of the all pervasive gloom? I do not know, but given that such fears are so widespread perhaps our future health will require creating new meaning and dreaming new visions to protect the hope that we can indeed survive and flourish.

There is at least one profoundly hopeful movement occurring in the hard sciences that I think will ultimately both help us to look at the universe more optimistically and have direct relevance for medicine. In 1976 Ilya Prigogine won the Nobel Prize for his work on the thermodynamics of complex systems. This showed that provided that certain conditions are met (and in our world these very commonly hold) complex systems are inherently self organising. Typically they get more complex not less. That fly did not die of entropy but it did die overlooking the present in order to consider the future. "Because this view is rooted in thermodynamics its implications are relevant for medicine just as they are already relevant for astrophysics, ecology, and neurophysiology."¹ The effects of such a revolutionary shift have yet to permeate medicine's search in the Newtonian framework for causes of disease largely in terms of cells. But when it is translated into more relevant concepts of medicine such an approach might suggest new insights into the organisation of evolving systems—for example, embryogenesis, growth and development, and family dynamics—and provide us with good reasons for shifting towards an interference with the complex realities of our patients' bodies and lives.

Since healing, be it of tissues or psyche, is self organisation par excellence autonomy and the space to work out one's own solutions may then be recognised as a scientific pre-condition of the best outcome not merely a humanistic value. To practise this might mean that we will really share our power with our patients, not reluctantly but in the full understanding that to fail to do so is to inhibit the chance for them to find their own best solutions. The question "Why does my stomach/head/life hurt?" lies unspoken at the heart of much of what goes on in the consulting room, and yet our medical view point often forces us to ignore it and prescribe answers that satisfy not our patients. A self organising perspective would emphasise that the real answer can only come from the patients by blending our valid, if incomplete, medical perspectives with their sense of the direction their lives should take. Since such a view of nature is deeply hopeful it may also help sustain us as we learn to live with the chronic terror of the bomb. Alfred North Whitehead remarked that it is the duty of the future to almost wreck the present into which it is being born. The patient of self organisation gives a hard edge to this and real hope that the future might not be as dire as it often seems. Perhaps as part of a self organising universe we have more on our side than we think.

References

1. Lifton R, Falk J. *Indefensible weapons*. New York: Basic Books, 1982.
2. Prigogine I. *From being to becoming*. San Francisco: W H Freeman, 1980.
3. Jantsch E, Waddington CH. *Evolution and consciousness*. London: Addison-Wesley, 1976.
4. Jantsch E. *The self-organising universe*. Oxford: Pergamon, 1980.
5. Wilson HR. *Mathematical models in neural science*. In: Haken H, ed. *Cooperative effects*. Oxford: North Holland, 1974.

STUDENT DRESS IN 1817 IN BRISTOL. In *The Biographical Memoirs: Bristol Infirmary* (Vol XI, p 130) there is a letter from the students to the honorary staff. It concerns the customary dress the students were expected to wear on the wards. The letter is undated but was almost certainly written in 1817: "Gentlemen, Fully assured of your good wishes for the students of this hospital, and well knowing your readiness to concur in any measure that may tend to increase our respectability, we beg leave to offer to your notice and approbation the following observations relative to the dressing gown (sic) now in use. We know it to be your wish that the students should always appear during the hours of business in their gowns, and if we have not uniformly so done, it has arisen, not from any intention to contravene your directions, but from the noted dislike to the gown now used, which is certainly no better than a butcher's frock... we feel it right we should be dissatisfied and disgusted as students and pupils in this house by some characteristic mark and conceive none so proper as the Cap and Gown of the University Student with some modification... we would even venture to be exacted that no one should appear in the wards without his cap and gown—except in cases of emergency... (This prompts us to request you to second our wishes by confirming to us that the Cap and Gown in exchange for the frock now in use and to explain ourselves more fully we have added a sketch of what we propose." This letter was followed by eleven signatures.

CHARITY AND DECENCY. Scene—Out-patient's Receiving Room in an Hospital, near a hundred miles from Smirfield. Present—STURGEON, POPULUS, PATIENTS. A POOR CRIPPLED WOMAN (addressing the STURGEON). I shall be very grateful, Sir, if you would be kind enough to examine my thigh. STURGEON. Is it not, my good woman? I see what it is (addressing the patient). It is an old case of disease of the hip-joint, gentlemen. POOR WOMAN. I shall be very thankful, Sir, if you will please look at it. I have suffered greatly a very long time. STURGEON. It is not a

may, I can do nothing for you. POOR WOMAN (with her hand half-concealed, twisting a sovereign between her finger and thumb). I wish, Sir, you would please to look at it, if it was only for a moment; it is a very great satisfaction to me, I trust. Well—well, at it now, my good woman, and remove your clothes. Ah! I think we can be of service to you. POOR WOMAN. Thank you, Sir, kindly. STURGEON. Wait a moment I'll write for you (sending a prescription). Here my good woman. POOR WOMAN (taking the prescription, and at the same time exhibiting a sovereign in the half-closed palm of her left hand). Thank you, Sir. (The girl held out at once catches the heart of the humane surgeon, who coolly places it in his breast-pocket.) STURGEON (to students). Respectable woman that.—Exit. (Lancet, 1829-30: 245.)

MEDICAL AMBIGUITY. An old physician, on being asked his opinion of a new remedy, that was praised for its extraordinary virtue in a certain disease, very gravely replied: "Dépêchez-vous de vous en servir, pendant qu'il guérit." A severe, but well-merited censure on the fond credulity, not of the public only, but also of many medical men. Hydrophobia is curing vast numbers at present: how long will it continue to do so? Brandy and salt are in vogue at twelve months ago; what has become of them now?—Veratrum is a sovereign remedy against neuralgia a few years back, and the chemists were making a thriving trade of it: at it is scarcely a grain: now it is seldom asked for. Unfortunately, there always seems to be an eager desire for the discovery of something new; as if there were not enough remedies, if we but knew when and how to use them. The clever workman is seldom changing his tools. It is true, in medicine as in dress, that what is new is nothing so new as that which is forgotten. Many of the wasted discoveries and inventions of the present day have been found to be but the resuscitations of what in long neglected or perhaps concealed. (Medico-Chirurgical Review 1844; new series 60:239.)

work load upon the normal routine running of the practice, and though our system was geared to managing without one doctor for holidays, any time longer than this became difficult because other holidays had been booked and because there are always patients who wait to consult a particular doctor on his return. We were faced then with this extra work load and the decisions still required by our new surgery, in addition to the negotiations that were in train to sell the premises. This had kept the remaining partners at full stretch, wrecked the holiday rota, and immediately called for an alteration in our working week to compensate. Fortunately, we were able to enlist the help of an elderly retired doctor who made himself available for surgeries at some inconvenience, which helped to lighten the load. But perhaps the most traumatic experience for the practice was realising that we had appointed a third new partner (sic) within 18 months. It had been a totally different proposition when the previous two had been replacements for retiring partners, while this time round it was to replace an active worker in full flight.

Selecting a new partner

Selecting a new partner to fit into our practice routine was the next step in our rehabilitation. Choosing from 100 applicants, all well qualified and vocationally trained, brought us the widest possible selection of ideas and backgrounds to consider. Nearly all had MRCP and DRCCO, several had higher qualifications, such as MRCP, FRCS, FFA, and one had the MRCCO. These did not influence or blind the partners one way or the other, our overriding decision being to find someone

with whom we could happily live and work, who would fill the niche left by our partner, and who had at least one interest outside medicine, on the principle that all work and no play makes Jack a dull boy, and one to test the patience, fortitude, and application of the hardest interviewee.

Our shortlist of 10 reduced itself to eight because two that we had selected obtained partnerships elsewhere. The eight whom we interviewed were shown the practice and taken to lunch. They were all admirable candidates, though the final two picked themselves because in every respect they fulfilled the criteria that had been laid down. The person we finally selected has just started and has fulfilled all the hope that we had for him.

Having regained the necessary number of partners, the pressure was relieved and we were able to move into our new surgery with optimism. Fears of discovering mistakes have been all founded and what we have created has exceeded all our expectations. It is comfortable, quiet, and spacious, and each partner has his own consulting room furnished according to his taste.

One last word remains to be said. With the double imposition of selecting a new partner to replace a trusted old friend, and the problems associated with the new building costing a considerable amount of money, the patients in our practice have been magnificent. They have been kind, understanding, and seem to want to share some of the problems that we have had in the past several months. It has been an illuminating experience for all of us, and one that we do not wish to repeat again in the future, ever. To our patients we are grateful, and to those of you who may read this all we hope is that they will never be faced with some difficulties that landed on our plate all at one time those several months ago.

Overlapping with General Practice

Advice bureau

BRIDGET GREEVES

Against one wall sit a girl with a new baby crying on her knee, a middle aged man with "unemployed" stamped all over him, a grey woman staring at but not seeing a leaflet called "What to do after a death," and a teenager with a head injury. Against another wall are a buttoned up young man with a short haircut, papers ominously marked "Personal File," a tramp repacking newspapers in a carrier bag, and a pregnant woman in a sari whose young son is softly translating a poster to her. If this seems like your waiting room, it's not—it's mine. What do my clients look like and the problems they bring, the solutions they seek, and the use they make of bureaux often have many similarities with the patients in your surgeries.

In appearance our bureau in Tottenham could well be a group practice or small health centre. We have a shop front leading to a waiting room, where there are no receptionists but, we "old" people, clear notices telling people to wait and usually several "old" clients who teach newcomers the ropes and sometimes use the waiting time to give advice themselves. About half of the people we find in the waiting room have been to us before, and they will wait to see the same adviser again. They will all normally have an interview alone with an adviser—there

are five in Tottenham—although there is a sometimes obtrusive telephone on the desk and occasionally a student sitting in. The middle classes say "I've never been to a place like this before," but the others broadly lump all agencies together and treat us like the doctor, the social worker, or the man at the building society, their son's headmistress—all are seen in rooms with three chairs, a desk, and bricks for the children.

No need to advertise

Why do they come to our bureau? It is clear enough when it is about claims of unfair dismissal from warning letter to industrial tribunal, which take up much of our time, as do problems with social security and debt, which require seemingly endless interviews and negotiations. Then there are landlords and builders to chase, divorce and probate papers to deal with, and immigration problems to sort out. This is the mainstream of our work, and we think that we are specialists in financial and employment problems and refer to experts when we are out of our depth.

But what about the clients with problems that do not have a specialist helping agency—the depression after a sacking or a bereavement, clashes between adult members in a family or with aggressive neighbours, loneliness, slight nuttiness? Surgery, advice bureau, social services—we each take a share

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BRIDGET GREEVES, MA, diploma in social work studies, organizer

Thinking About the Unthinkable

Death of a partner

R J R LEWIS

My mother used to tell me that the recipe for a happy and successful marriage was to ensure that you marry your best friend. A successful partnership requires a similar duty. Twenty two years ago such a duty started in our rural practice and continued happily until last summer. Two brash young men with a united appetite to general practice and patients, we were drawn together by a fortune of geography because we lived in neighbouring villages. We were close in age, outlook, upbringing, education, and ideals, though our outside interests were totally dissimilar. We chose to join forces so that we could enjoy our leisure off duty as well as interchange professional knowledge and give mutual help. From the beginning of our partnership we did not mix socially so that we did not see much of each other after we had left work. Somehow we trusted each other and seemed attuned in our separate patient contacts. We never had to think about what the other was doing because we knew that, although we each had a slightly different approach to particular problems, at the end of the day we ended up with the same result.

We watched the practice grow from a two man set up to its present size of six; indeed, we had had only one new partner in nine years until 18 months ago when because of the rapid retirement of two partners in one year for various reasons we had to select two new junior partners. These partners were chosen with, we think, much skill and pride to help us in carrying on the good name that we had inherited. With these appointments out of the way, we began to design new surgery premises. We started with an acre of land in the middle of the village next door to the memorial football ground, which was at that time an orchard—an ideal quiet situation to enable us to begin with a clean sheet of paper.

Many hours were spent travelling to look at other buildings and talking to doctors about their ideas, and many more hours were spent arguing and discussing among ourselves about the end result. This was a combined effort into which we all entered enthusiastically and, surprisingly, there was very little disagreement about the major items and construction of the layout. Of course there was argument about the finer details, because each partner wanted the furniture and fittings in his consulting and examination rooms to accord with his taste. For the most part, however, we decided individually where the wash basins, electric points, couches, desks, switches, lights, and so forth were to be positioned. We were surprised that having instructed our architect on how we wished the building to be constructed, that the final plans he produced closely approximated to the ideas with which we had started. The move into our new premises was to be a red letter day and one of which we would be proud, though a little apprehensive in case anything should go wrong or to be a disaster. The builders were on time with their estimate,

and we knew that it was only a few months before we would take possession of the keys and move in.

Each of the partners had interests outside the practice, so that we never wanted to play tennis, golf, sail, motor race, or climb mountains all at the same time. Only two of the partners had small children below school age, one had children at school or university, and the remaining three either had none or else had grown up children. Therefore holidays did not present too many difficulties. Among the partners one was an enthusiastic and very competent sailor, who owned his own yacht and had his ocean-going yachtmaster's certificate. He was always having his leg pulled mercilessly about ensuring that the cork was in position and more seriously that the wind was set fair to bring him back to the surgery on time after his holiday, a legacy of some years ago when he calmly rang one Monday morning to say that unfortunately he was still on the island of Alderney and there was no way he could come back until the Channel storms abated. That, of course, caused much trouble in the practice because there were only two partners at the time.

All systems shut down

Two months before the appointed time of moving into our new surgery, when we were looking forward to this happy event with eager anticipation, our sailor left to go to travel on holiday to France with his family. He left at lunch time one Friday, having just helped us with an interview for a new junior receptionist, and as he walked out of the door with our good wishes ringing in our ears, he walked away and never came back for one moment that we would never ever see him alive again.

The next day while I was sitting in the Saturday morning surgery a voice over the telephone calmly announced that our partner had died. He had been ailing for some time, but had started while he was on his boat leaving England for his sailing holiday. He had never had a day's illness in over 20 years apart from a migraine headache, and no physical abnormalities during his 20 years of practice. He had been ailing for some time, but this news was relayed to us total paralysis set in. There was no way of collecting one's thoughts and no way that further rational surgery consultations could be continued, for it was quite impossible to put any logical thought into diagnosis. All systems were shut down. To someone accustomed to instant decisions and shocks of great magnitude among one's flock this was the worst blow that could ever be administered. Somehow objective decisions affecting patients are remote and one can always rise above them even though one does identify with the patients, but here the blow was mortal and for the moment positively crushing. It was real and affected us personally as it could not be. After death had ever done before. You cannot break up a partnership or a duty of many years standing without this sort of remorse or even self pity being the result.

We immediately set about advertising for a replacement partner, having first obtained the sanction and permission of the Medical Practices Committee. For several months the extra

of these cases, and there is an intriguing study to be done on the choice made by clients. Time and again the opening sentence is "Last year you helped me with my faulty immersion heater. Now my husband's left me." The help or support on small matters that we have given in the past to clients or their neighbours creates more work for us than any amount of advertising or services. The mother of a 25 year old man who was spending weeks in bed with the curtains drawn and the sheets over his head had tried all three professions in turn. None of us helped. The doctor said "Is he a danger to himself?" The social worker said "Is he a danger to others?" And I said "In law you've got every right to turn him out of your house." There was no magic solution for her, but she might have accepted that fact from someone she had had contact with and found helpful before.

Another client, by choosing to come to the advice bureau, was making a clear statement about what aspect of her problem she wanted sorted out. She was living in a very unhappy atmosphere at home with a teenage granddaughter who was used in knots over her relationship with her stepfather there. "Miss Greaves, she sighs so deeply with worry she wets her bed." She did not consult the doctor about the bedwetting, or the social worker about the relationship, but chose to negotiate rehoming for her and her granddaughter alone, so she came to us. A long shot, but surprisingly it worked. We can be brought down to earth, however, by some of the reasons that clients give for their choices. Some have come to the bureau "because the surgery isn't open in the lunch hour," and one time a doctor phoned me about a client who took a problem about a landlord to him "because there are too many stairs at the advice bureau."

Grey areas

So some problems are essentially grey areas and clients are going to go on choosing for themselves which type of professional help they want, often with a logic that escapes us. There are others where each profession shares a part of the same problem. Most of the cases on which we contact local doctors concern claims from the Department of Health and Social Security or compensation claims that need medical evidence or support. I confess that it makes me jealous to know how good-looking doctors, can be in small areas of the law and bureaucracy. Those requests—which must sometimes seem endless—for "a doctor's letter" may result in precious medical evidence in housing or compensation claims, but the overriding "health" sections in the social security regulations are, it is worth remembering that a scribbled note from the GP can get £380 per week extra for special heating, cash for extra laundry expenses, and valuable grants for heating and lighting. There have already been several test cases using key medical evidence on the catch-all Single Payments Regulation 30, which is paid out when it is seen as "the only means by which serious damage to serious risk to the health or safety of any member of the assessment unit may be prevented." (The assessment unit is a person, you must note.)

I sympathise with doctors who must sometimes in the middle of a busy surgery think that dealing with some requests are a poor use of their time—and possibly there are also thoughts about pettiness and scrounging hovering below the surface. But when so much of my time and expertise with clients is spent trying to make ends meet to prevent other parts of their lives collapsing your brief notes and certificates may mean the difference between the success or failure of my efforts. The doctor's waxen and crucial evidence of effect of injury in compensation claims is being evaluated. Our lawyers tell us that a report that indicates that a further appointment with the doctor is or was needed—even if only a check up in six months—adds £665, and sometimes even to a second appointment, the legal and medical professions speak about compensationists, but I would put in a plea for the genuineness of those lingering

headaches, the stiffness, and the tension. Claims for compensation drag on endlessly, and require going over the same ground repeatedly and reliving the accident or the attack. The pain and the memory is "outstanding" as long as the claim is unresolved.

Fit for what?

Most topical, I think, is the doctor's present role in pronouncing fitness for work. Several conversations (and a few arguments) with local general practitioners over shared cases have convinced me that the official printed wording on medical certificates is now inappropriate. A 50 year old man with a weak chest, or back trouble, or a history of time off sick may be fit to be at his home, but not fit to return to work. But where are all these life-or-death cases, they all seem to be automatic. So, in plain English right now he is "unemployable." If he has been off sick for more than six months he will have been getting £31.45 invalidity benefit (or disablement benefit) up to £53.60 if it was a work injury. Your certificate saying he is "fit" moves him straight down to £25 a week unemployment benefit. If his prognosis is true and he is still unemployed after a year then all smiles stop; no one gets more than a year's unemployment benefit. If he is on his own he will be "cushioned" by being on the basic supplementary benefit (£25.70 per week plus rent and rates paid), but if, say, his wife is working they will be expected to live off her wages instead and just claim rent and rates rebates. It is a difficult area because so much depends on your point of view. If it is all a case of playing the system whose system shall we play? The question you are asking is, "Is he fit for work?" and the question I want to ask is, "Is there any work he fits?" Each makes an assessment based on a narrow view, but surely what is normally needed is a broad view of what is best for the client. Even if on occasions the general practitioner may be overridden by the doctor at the Department of Health, nevertheless if he feels strongly enough he can provide invaluable backing for the patient at a medical appeal tribunal, which may win the day.

So sometimes the client uses the bureau in the same way that he might use a surgery and sometimes he uses it in a complementary way, but often we find ourselves being asked questions that are "proper" to doctors work. It is one thing to be asked for guidance on how the medical system works—signing on, dentists' charges, claims for negligence—and then also about the ubiquitous second opinions from private doctors. Few clients seem to ask for a second opinion, but some do. Some opinion though their general practitioners, and those who are often too embarrassed by the implied break in trust. There are other questions, too—many of them come under the broad heading of "Am I mad?" But there are also those who seek a much more thorough grounding in medicine than any of us has: "Will I have this backache for ever?" "Can I take these pills as well as Ex-Lax?" "My doctor says my daughter will stop being oversexed at 27. Is that right?" Don't panic, we do not attempt quick answers, but perhaps having a medical adviser, in the way that we have a community lawyer to advise the staff on law, would help us to sift out the relevance in the hearts of "Am I mad?" and "Is my daughter oversexed?" my toe nails with these heavy nosebleeds." "They put a battery in my gun to strengthen my brain." "My doctor says I can't do nothing ever again."

I have a faint idea of an advice worker having an office in or next door to a group practice, picking up work from a shared waiting room, and offering a joint service for the physical as well as the emotional and the social. On the other hand, too sensitive a medical ear in advice work is dangerous. The first "corried telephone call on a sleepy Friday morning said, "I've just had my breast removed." (I started thinking of babies and mothers and the fact that the breast was complaining the wallpaper is falling off.) Relief—it's all about childrens.

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