General Practice is the Art of the Possible: but we are turning it into a tyranny of the unworkable

Reflections on our inspections regime

David Zigmond

There used to be a tacit assumption that healthcare (and welfare generally) was mostly imperfectible, but that practitioners would generally do their best. All that has been replaced by something very different.

This long letter – to an NHS inspection manager – shows in detail how we lose our professional trust, identity and integrity.

Introduction

There used to be a tacit assumption that healthcare (and Welfare generally) were complex, imperfectible activities, but that practitioners usually could be trusted to do their best. Managers then occupied an important background role providing structure and support; rarely – with a rogue or failing practitioner – they briefly occupied the foreground.

This largely trusting and good-enough culture has changed utterly into one of zero-tolerance of imperfections. Attempts to control every aspect of practice have become draconian. In this unwise, unviable and humanly alienated new world, managers are now (often unhappily) dragooned to serve as commissars and overseers. The results become very different from the design.

This letter, about a recent NHS inspection, illustrates our problems.

October 2016

Graham Boullier

Head of Practitioner Performance and Revalidation

NHS England

Dear Graham

Case Investigation report by NHS England. August 2016. My response

This long response (though a small fraction of your report's 115 pages) comes at the end of my four decades as a GP. As you know, for many years I have been writing to NHS Executives with my disagreements and caveats about accumulating reforms and procedures. This is my last letter as your employee and thus represents a kind of *Last Will and Testament*: I hope this will explain my choice of working ethos and its many consequent decisions over many years. In particular I wish to highlight some specious assumptions, and then misconstructions, that have led to the wide discrepancy presented here – between the real-life and long-term quality and safety record of my practice *outcomes* (extremely good) and this formal, abstract report of compliance to your expected *process* (poor). The reason this discrepancy deserves such long consideration is because such tendentious distortions of perception and judgement are a growing part of what is ailing our NHS. Understanding these problems is certainly important, but not easy: that is why they continue.

So, I start my response with these larger themes: they require much thought – I hope I will be joined in that. Later I focus on examples specific to the report. To aid clarity

and future dialogue I have annexed, itemised and numbered some of these arguments and examples. Elsewhere I bridge these with freer prose. In view of the problem's wide-ranging relevance I have written for readability and accessibility far beyond our circle. Bold and italicised type highlight some key notions.

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A: Background and wider and considerations

First, I want to say I have always supported the mission of such reports: to ensure (or, at least, facilitate) probity, safety, reliability, humanity and good collegiality. Few would disagree. But the tricky problems lie with implementation: what is the best way, and when – regulation or facilitation? How do we assess these things, by an informal kind of holism or by a formal kind of atomised proceduralism? What is the cost of over-zealous attempts to regulate rather than facilitate?

Analogies: almost all political programmes and manifestos sound laudably intentioned, at their launch: what they then lead to is often very different. This is similar to overstrict parents. Early compliance may be easy but is usually illusory: later difficulties will usually pervert or undo the parents' sincere belief in the beneficence of their control – 'we only want the best for them'. I think this kind of discrepancy – between design and result – has become massive in our NHS. Your report echoes such discrepancy.

My long view perceives that **our health service is struggling with (or against) this doomed folly: that we can endlessly improve our care with evermore regulations,**

commands, data, monitoring and penalties – that with enough rules, sticks and carrots we can get the best out of other people.

But **our profession has become first saturated, and now sick, with such behaviourist manipulation.** This is evident in our fractious and plummeting staff morale: it is reflected in hazardous increases in staff sickness, premature retirement, career abandonment, intra-organisational litigation and feeble recruitment.

We have replaced our previously (mostly) trusting 'family' of healthcare with a mistrustful 'factory'. There is now little place for professionalisation in such a factory: all judgement and decision making becomes executised to specialist 'experts' away from the factory floor. On the work-front doctors now are – increasingly – expected to be mere conduits and instruments to receive and implement their received instructions. Professional experience, holistic wisdom, judgement and autonomous intelligence first flounder, then become defunct. I later identify how such distortion and damage is manifest in your report.

As our managerialism has turned officious, the price has become unsustainable. Most evident is the demoralisation and devitalisation of our workforce: underneath is the unremitting erosion of that kind of autonomy necessary for the unfettering of doctors' intelligence and thus our best and most personally nuanced care. Analogy from Archimedes' principle of displacement: the more we insistently push in the artificial intelligence of institutional management, the more we inadvertently push out the natural intelligence of individual practitioners.

The diligence and original intent of this report is not in question. Yet in many aspects – sadly – it is an example of such displacement. Even with good intent, as so often now, it serves as part of a system of remote control: such remote control is designed to disregard human meaning and context. This is a core explanation for our growing failures.

How does this happen?

Later I return to your evaluation of my Benzodiazepine prescribing: it is a good example.

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Why have we created these unworkable anomalies? Are we on the wrong path?

Consider this: '*Politics is the art of the possible*' (Rab Butler, 1960s).

We can transpose this epithet as a wise and pithy guide to the challenges and conundrums of General Practice. Over many years I have had thousands of consultations. I always attempt to ask myself: 'Why has this person come to see me? Is there an important, and very different, subtext? What can I best do, or say, that will make a difference now, tomorrow, and then next week, month, year, decade…? Who else do I need to consider or influence, either directly or indirectly? In the process of all this what can I most safely disregard?'

This kaleidoscope of possibilities comprises the technical and human yarn of General Practice. The bulk of our relevant skills are subtle and depend on our ability to rapidly fashion holistically intelligent responses: how within a short time – say ten minutes – can we edit and choreograph often complex, multivalent human and biomechanical compounds into the most meaningful and pragmatic 'take-away' forms – something that makes sense to the patient, the doctor and the responsible authorities. Note this sequence: it should, generally, represent a hierarchy of precedence. But modern management tends to reverse this – so that management considerations become preeminent and the personal becomes relegated. This reversal is particularly damaging within pastoral healthcare (ie that which cannot be decisively and rapidly fixed by technology). Again, such problems are reflected in some of the anomalies in this report. They will be sampled later.

So, pastoral healthcare – that accounts for much of General Practice – requires a kind of skilled juggling or choreography: our cardinal task is to make meaningful whole patterns from often clamouring and conflicting realities and interests. But we can only do that if we selectively make space: to know what to defer and what to disregard. As with the stage choreographer we decide how and when to move the 'characters' around the stage. What would become of a play in which all the characters were at the front of the stage and spoke equally loudly and at the same time?

This choreography is the holistic art of medicine. **Holism – the imaginative vision of unobvious, but meaningful, connections – is *not about trying to fit everything in*, it is about knowing *what to leave out*, so that the connections can be seen and respected**. This is like the artist who best captures a scene or object by selective

perception and representation: to attempt to include *every* detail is not only impossible but destroys the communicated message of the art.

I have always regarded the art of those choices – knowing what is most important to attend to – as being central to my professional skills, responsibility and identity. But – and here is a thorny problem – these skills cannot be directly controlled by a governing agency. Indeed, the attempt to do so often leads to much clumsy, sometimes harmful, human misunderstanding and misattunement. This accounts for our many problems throughout pastoral healthcare. My anomalous Benzodiazepine prescribing – presented later – provides an illustration and analysis.

B: The report. More specific background, items and analysis

1) *Why the report and what is it?*

This report was instigated, I think, due to me being identified as an 'outlier': my above-average Benzodiazepine prescribing.

The report's major concerns are in the domain of 1) record keeping and 2) prescribing. I deal with these separately. Due to the more general importance and complexity of Benzodiazepine prescribing, my response is particularly focused on this.

2) *Vernacular and official realities: real-life evidence* .v. *official reports*

There is a massive discrepancy between my very long-term and excellent record with, and feedback from, patients and close colleagues, and this report. This discrepancy must be acknowledged, profiled and understood before the report can be properly evaluated. Here is the contrast:

a) Real-life evidence. My 39 year career as a Principal GP – serving in the same small practice – has been exceptional in quality, safety, reliability and popularity. Throughout that long period I have never had a serious complaint (ie needing formal investigation or hearing), any kind of litigation, or any kind of evidently culpable untoward death or on-premises accident. The practice has remained remarkably and enduringly popular amongst patients and staff: almost all leave with reluctance and because of unrelated life-changes. Independent patient feedback has consistently reflected exceptional quality since records began, several years ago: my last IPSOS/MORI poll (July 2016) clearly showed mine to be the favourite local practice overall.

The outcome – the whole – seems **highly satisfactory.**

b) Official report imputes a very different picture of fecklessness or recklessness. A picture emerges of serious and untenable unsafety.

The process of compliance – the parts – are alleged to be **poor**.

How can a) be so discrepant with b)?

Which should we believe?

c) The purpose of the report, it seems to me is:

i To identify possibly harmful anomalies. If present, are these due to the practitioner being a DSR (duffer, slacker or rotter), or a rare group such as

'medication fetishist'? (eg a prescribing doctor, who, for obscure and solitary reasons, has a mistaken and overvalued idea about an intervention or medication whose fixation then distorts or displaces his wider, residual competence of practice).

ii If no other evidence can be found for a doctor being either a DSR or medication fetishist (or similar), then is there an alternative hypothesis?

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In brief, your report may have identified an anomaly (my above average Benzodiazepine prescribing) but, in my view, does not clarify further what this is, or attempt to do so. There is *no* other evidence of hazardous history or activities (eg DSR or fetishism). No other hypotheses are considered.

In this response, later, I offer an explanation. All this will be considered in my survey of Benzodiazepine prescribing.

3. *Record keeping*

Until relatively recent times my record keeping was entirely handwritten. For decades I took pride in conveying clear, readable, orderly notes with devices to highlight important and enduring problems and to cross-reference these (eg with previous dates) in order to provide a skeleton of a narrative. Colleagues frequently commented on the interest and merits of such note keeping.

I transferred this modus operandi to electronic records. I aim for clarity, concision, precision and imaginative cross-referencing (eg date-referencing functional polysymptoms to a recent bereavement). To do this I record only significant (ie interesting and important) features and exclude routine unremarkable findings of history (or their absence). For example, a healthy 50-year-old man with diarrhoea might have the following entry:

> **Diarrhoea**. 3/7 Mild. Slight crampy lower abdo. pains only. Nil else o/q or o/e (thorough). Wants Rx, thus Rx Loperamide and usual advice. RV pm.

Or

> **Diarrhoea**. 2/52. Increasing despite usual OTC Rx. Unprecedented. o/q recent tiredness + malaise. ?Weight loss, but unsure. FHx of bowel Ca. o/e Looks unwell. ?pallor. Nil else (PR not done). Imp: ?Ca URGENT Ref. > Colorectal @ GST.

Note that I make a judgement as to what is relevant and then trim my text accordingly. I do not want the reader's eye or mind to be distracted by irrelevant clutter. A large part of *the art of good record keeping is about knowing what to leave out*.

Yet for a complex compound of reasons – including our increasingly litigious culture, and the endlessly effortless transmission and storage capacity of computers – our clinical documents are urged to become increasingly and exhaustively overdetailed and prolix: lengthened by all kinds of procedural associations and peripherality 'just in case …'. Such densely defensive clutter may now be deemed 'correct' but becomes enervating and then unread. The paradox here is clear: the more defensive and procedurally cluttered our communications, the more inassimilable and risky they become.

Our service becomes compromised by the consequent email encephalopathy. I see many current medical records and communication that signal – unintentionally – the exhausted and saturated distraction of the practitioners: an abandonment of comprehensible sentence structure, guiding punctuation, delicate vocabulary, thoughtful phrasing or pauses for paragraphs. Often, all available data is sped out like a car slewing on wet roads: inadvertent misspellings, elisions and conflations crammed with excessive and often incomprehensible detail pumped into required templates. 'Oh, but it is all there …' a defending lawyer or Contract Manager might argue. But who for?

So, while ever-expanding documentation and defensive signalling may be understandable in intent, it has become often unmanageable in content. Our exhaustion and insensibility become contagious.

There are many examples in the report of the investigators behoving me to provide greater detail in my records: I think these both unnecessary and would add to obscurity, by adding inert clutter. Later sections will show examples.

4. *Prescribing*

This received the most adverse attention in the report. The problem territory is large so it is worthy dividing it:

a) Risks .v. *benefits. How do we decide?*

Similarly to 2c above, I presume the report's task is to identify prescribing risk (eg DSR or drug fetishist) or profligacy (excessive or too expensive).

It is only the former that invokes this report's judgement, not the latter.

Some general but important points: all prescribing and interventive medical practice carries some risk, much like many of our life activities. Much of the risk is unknown (eg innumerable unresearched drug interactions; the morbidity incurred by emotional turmoil; the damage from undisclosed or concealed non-compliance). Like 'fashions' in newsworthiness, our risk-concern is selective and not necessarily rational: NSAIDs invoke much more concern than a decade ago, even though the research knowledge was then known; Benzodiazepines arouse much more professional anxiety than anti-psychotics or psycho-stimulants (for ADHD) – more of this later.

It is tempting to equate (relative) prescribing safety with conformity, eg to follow the majority. But this is often spurious eg Barbiturates in the 1950s, Thalidomide in the 1960s, Practolol in the 1970s, Co-trimoxazole in the 1980s, HRT in the 1990s … diesel cars in our cities in the 2000s. Majority practice is not always right: different decades often bring different perspectives.

So, prescribing conformity is not always the safest practice. What about 'prescribing attitude'? Doctors who are thoughtful, caring, observant and questioning are rarely, in my experience, hazardous in practice. I have tried to be such a practitioner. How I prescribe Benzodiazepines will – I hope – become clear.

I am puzzled that the report does not mention one of my conspicuous and consistent prescribing safety initiatives: since starting computer generated prescriptions I have carefully annotated every prescription with relevant details as to what the

prescription is for and other clarifying details. Eg re: Amoxicillin. 'For Chest Infxn.'; re: Clopidogrel: 'To protect heart (Ex Myocardial Infarct + Stent 2/16. Take til 2/17).' I have found this very helpful for all: patients, carers, other clinical staff, receptionists, pharmacists. It is a simple, zero-cost device which has provided my practice with much clearer, safer communications.

Perhaps my safety initiative is omitted from the report because it is not in an endorsed checklist of evaluation criteria: if so I suggest loosening and opening the authority of such a checklist.

b) Benzodiazepine prescribing: a pharmaceutical Rorschach

This constitutes a major concern in your report and arises in a large, complex and already contentious area of practice. My response here must apprise this. Again, for clarity, I use the following sub-divisions, travelling from the most general to my own particular prescribing patterns:

i *The medical model and human predicaments*

The biomechanical approach to healthcare depends on certain standardised activities: diagnosis, treatment, care-pathways, statistics and data collection and, most recently, management by algorithm.

For some circumscribed physical conditions this is indisputably the best way: for example, there is only minor technical discussion about the best way to treat Appendicitis, Streptococcal Tonsillitis or a hip fracture. Other approaches are easily deemed ineffective and thus irrelevant. Patterns of prediction and intervention have great consistency. There is little variation.

But our medically-presented behavioural or psychological problems are very different: doctors here have much less special knowledge and influence that can make them so effective elsewhere.

For example, problems with mental distress, drug or alcohol addiction are much less likely to be swiftly and efficiently cured as they so often are with certain physical illnesses. With these ailments there are many exceptions to the patterns we formulate for prediction, care or treatment: sometimes opposite approaches may be effective in different individuals. Often with these kind of afflictions the most decisive therapeutic influences do not come from any kind of medical staff but from the patient finding fortuitous love, a religious faith, an epiphany, an absorbing cause or a new social circle. In such an arena the doctor needs to exercise very different kinds of judgement and skills.

This largely accounts for why working with sufferers of BAMI disturbance (behaviour, appetite, mood or impulse) is so much more difficult and interesting. It is full of paradoxes and exceptions; it cannot be standardised and measured with anything like the reliability we find in physical medicine; our management can facilitate but cannot determine… Clearly we cannot fix broken spirits like broken bones.

Within the realm of BAMI disorders, therefore, there is so much vagary and variation that attempts to standardise assessment and therapeutics often create more problems than help. Here the genuine interest of the practitioner and the

quality of rapport that is established with the patient have been repeatedly shown to be the most therapeutic factors.

My long-term contact with BAMI sufferers certainly bears this out.

ii *A long, wide and bullet-pointed view of Benzodiazepines (BZPs)*

- BZPs were preceded, from the 1930s, by Bromides and Barbiturates. The latter persisted into the 1960s: they were certainly potent as hypnotic sedatives but were easily overdosed – often accidentally – and then rapidly lethal.
- In the mid-1960s the BZPs were introduced. They were less crudely potent than Barbiturates and very much safer – their lethality was much more remote and seemed only to occur when mixed with large quantities of other drugs, or from secondary accident.
- Fifty years later this remains the general view: BZPs are considerably less toxic and hazardous than most related antidepressants and antipsychotics.
- **BZPs are certainly much safer – even in excess – than excess alcohol**, which is often used by patients instead, to self-medicate. Paradoxically, alcohol has no requirement for professional regulation or supervision at all.
- BZPs can form habituation and dependency patterns **especially in individuals or situations when skilled guided support and containment is not provided.** This happened a lot in the 1970s and 1980s: careless and uninterested doctors would prescribe large quantities of BZPs as a ploy to keep the tranquillised patient uncomplaining and away (from the doctor). BZP habituation and dependency then become rife: addiction less so.

- BZPs consequently got a reputation as bad as their bad prescribing doctors. This was (in my view) a false conflation: the doctors were far more antitherapeutic than the tablets.
- The cautions and caveats that were so pertinent to the 1970s and 1980s persist now as a kind of 'keloid scar' ie an overgrowth of reparative tissue.
- Many practitioners and researchers are now challenging this professional orthodoxy of draconian avoidance of BZPs: they maintain that **within a matrix of good pastoral care BZPs are often the safest medication options.**

iii *A brief personal view and philosophy of BZPs*

- As with all psychotropics I aim always to prescribe as a second option, after more natural/healing options (eg the innumerable kinds of bespoke guided support and containment = 'psychotherapeutic influence').
- When I am dealing with severe damage, disturbance or decompensation I try to employ the alliance of mental health or addiction services, etc. I welcome this synergy. Often, though, it does not work out: resources have become thin, delayed, cancelled or of poor quality contact. Then I have little or no help in coping alone.
- **In this respect my BZP prescribing pattern also reflects overflow from problems elsewhere. This is like tarmacked front gardens causing flooding elsewhere, in the lower parts of a town.**
- With all such patients I do my best to provide guided support and containment within the limited time and resources I have. Monitoring, of course, accompanies this.

- I rarely think of any psychoactive drug as my preferred and first option, but they may be the device that helps achieve a tolerable survival: sometimes they are a bridge to other influences (eg by making socialisation or Counselling possible).
- I am thus never cavalier, reckless or feckless in either my prescribing or personally engaged follow up.
- My prescription of BZPs therefore represents my best judgement as to how to contain, palliate and engage with individuals who are raw with often inchoate damage and pain. If I could achieve these without any, or with much safer, medication I would do so. **Certainly, I consider the way I attentively prescribe BZPs is much safer than their lonely and unaccompanied retreat into alcohol and street drugs – this is a common response to poor engagement with our services yet, paradoxically, often lies outside official statistics of Service Providers**.
- Because I have developed a reputation for offering this kind of help, many patients have sought this from me. I always try to engage the other relevant agencies, but often their contact is not helpful: this is a complex issue meriting separate investigation.
- As indicated in i), above, there are frustratingly few kinds of clear 'right' and 'wrong' when entering this kind of BAMI territory: we, mostly, act with our best faith, judgement and heart and with very limited science. None of us here can act with the reliable precision, predictability and outcomes of – say – the ophthalmic surgeon.

- In this marshland no-one does as well as we would like. Those services more rigid in their protocols may prescribe less but often lose rapport with their patients, and then their attendance … and then what?

  I have often taken the other course: my aim is to keep the patient engaged: as long as I can do that all sorts of other developments and influences may be possible. This is not so if they are lost. BZPs here are, often, I think, a very acceptable compromise to achieve that.

- Such processes may be very long. But I am a long-serving GP with substantial psychiatric experience and much patience for such things. My results are often eventually good, but not easily achieved: like reeling in a large strong fish, timing and patience are essential to avoid the line snapping. This involves skills now perishing throughout pastoral healthcare, particularly with BAMI: there are many snapped lines and distressed, disengaged individuals.

- In brief: **BZPs are most likely to do harm by dependency when the patient is not engaged adequately with some kind of skilled, guided support and containment.** I strive always to provide this. The results can then be very different.

iv *My prescribing anomaly: institutional responses*

- For about a decade my otherwise unremarkable prescribing has shown me to be a regular outlier in one area: I prescribe significantly above average BZPs.

- My attitude to this has always been keenly Socratic: I want to understand it better. I certainly have never attempted to parry, avoid or obfuscate any issue – I recurrently tried to *invite* discussion.

- Although I thought I could, possibly and in part, account for my high BZP prescribing (by considering the material in the above section), I acknowledged that there may be more that needs exploration and clarification. Without this clarity we cannot reach a sound judgement: unfortunately this is where we have stalled (see below).
- I suggested, therefore, the help of two kinds of expert:
  - *Statistical/IT* – to verify that this is a 'real' problem, not one due to a technical glitch, duplicate entries, errant coding etc. If these were excluded, then we could identify particular patients.
  - *Clinical* – with either an Addiction or General Psychiatry Consultant, to review each of these patients jointly, in person, in one or two designated clinics. This would get us beyond data to much fuller personal and clinical understandings, with their many predicaments. This might also offer some new and opportune therapeutic leverage with the identified patients.
- **I made this suggestion, repeatedly, for several years. It was never taken up.** I was given no explanation for this parrying.
- (On 12.7.16 the Medical Director of NHS England south London verbally apologised for this oversight, but this cannot now retrieve this opportunity for understanding and influence.)
- In the last couple of years I managed, coincidentally, to introduce some of these patients to senior specialist colleagues (two Consultant Psychiatrists, a Clinical Manager, a Medical Director, a Chief Executive Officer – and Clinician – of my local Mental Health Trust): they were all helpful in attitude, but helpless in effect. Haplessly they explained how they had not

the staff or the facilities (eg Day Centres) to deal with people with these kinds of diffuse disturbance, damage and distress.

Yet there are many of them. How should I respond?

- For many years I attempted to raise awareness and debate about these matters by writing, speaking up at meetings and lobbying anyone who might have any influence. (I managed much collusive commiseration, but little change.)
- How did NHS management respond? The next I heard was this investigation … and now this response.
- Maybe now – after this long and elliptical trajectory – something positive will evolve.

I shall welcome any enabling discussion.

Yours sincerely

David Zigmond

C. Appendix. Itemised caveats and disagreements

To aid digestibility of this very wide-ranging and long response I have separated, until last, the more precise analysis of specific examples in the report.

I hope that the previous, more general, survey will lead to easier understanding of my objections. For brevity I have included only some of the examples I found contentious. For each I refer to the code as in the text of your report.

3.1.8s Acute mild Sciatica in a well person, without other more serious symptoms, does not usually benefit from an examination. However, early review is always welcomed, certainly if the patient is not improving – examination and further investigation is then more apposite and cost effective.

3.1.19s Epistaxis. As 3.1.8s.

3.1.6p Wheezy Chest Infection. Much as 3.1.8s: If the condition is mild and the patient a non-smoker and otherwise well, a peak flow reading is probably unuseful data clutter. Of course, this can always be reviewed.

3.1.11p Cough in toddler. Much as 3.1.8s. My skill and experience lead me to quickly know if such a child needs a more thorough examination. In forty years my accuracy rate has been very high. Access to me has always been easy: when I am wrong I rapidly change course.

This is professional responsibility: it is being taken from us.

3.1.35s & 3.1.2s No, I do not use QRISK2 or similar computer tools to help patients with risk factors. Again, I believe that my professional knowledge, skill and imagination will inform me better than any computer template as to how – within a few minutes – I might best address their lifestyle and their coping mechanisms (or otherwise). Here good, mobile intelligence is far better than static, algorithmic, artificial intelligence.

3.2.4p, 3.2.8p & 3.2.17p. See b iii) of my account. These people had much hazardous and chaotic damage. I always attempt to refer them to drug and alcohol teams, but their engagement and rapport there is often poor: the reasons are instructive. I have written about this, extensively, elsewhere.

Meanwhile I have done what I can with what I think are the safest compromises.

Incidentally, I had many years' work and training in psychiatry.

3.2.10p Acute Gout. The man's Gout was very painful. A *short course* of Diclofenac carries a very small risk, even with Citalopram. (NB the patient was rapidly relieved. There were no adverse effects.)

All prescription carries some risk and thus compromise: see 4a, above. We can only offer our best vigilance and informed judgement.

3.2.13p Methylcellulose for Obesity. This is often helpful, when offered with encouraging advice. Unlike many contemporary approaches, it has almost zero serious risk. It used to be more common practice, but has fallen out of fashion. Like much fashion this may be a herd phenomenon: other reasons are not obvious.

3.5.1p Knee pain. Much as 3.1.8s. I know when to examine such a patient, and when to change my mind. These are my professional skills. Much as 3.1.11 also.

3.5.2p Ditto. I say a lot when I deem it useful or interesting.

3.5.14p Young man binge drinking of holiday. What sort of advice do you think I gave?!

3.5.17p Guided alcohol withdrawal. I do not agree with the inspectors. For a routine GP consultation these records are concise, useful and accurate. No, they are never 'complete'!

3.5.18p Erectile dysfunction/Viagra prescription. I believe my consultations are subtly skilled. I do not record much detail of my enquiry or encouraging advice unless I am expecting complex and persistent problems.

3.5.21p PCOS, hirsutism, Eflornithine. This was a first consultation with a recent immigrant from India. She is highly intelligent and wanted referral for her well-documented PCOS. I think these records are pretty good as a first, and routine, GP entry.

3.5.9p Sciatica, alcoholism, diazepam. See 4b, above re: what guides me to make my best judged compromises.

Section 1.3 Hypnotic/BZP prescribing. Much as 3.5.9p. It is worth reiterating that there is much division and revision of opinion about this. I have had recent long discussions with three Consultant Psychiatrists, a Medical Director and Professor of Primary Care Mental Health: they all agree with my notions in 4b. (Details on request.)

3.5.5p Emotional turmoil, sensitivity rash, Promethazine. I do not think I needed to record much about this minor rash which was probably an expression of disturbed emotions: I was reviewing him soon, anyway.

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I hope these noted comment are clear. The list is not exhaustive, and I hope not exhausting. I welcome discussion about any of these examples.

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