The Ulster Medical Journal, Volume 66, No. 2, pp. 115-122, November 1997.

Living in interesting times

Presidential Address, Ulster Medical Society 16th October 1996

Lewis Miller, BSc, MD, FRCGP

INTRODUCTION

I must begin by thanking the Society for appointing me as President. This is a professional honour which I had never anticipated. It is said that adversity sharpens the mind. Certainly the prospect of addressing you induces a degree of angst which I hope to put to good use. One's first though is inevitably "What am I going to say?". However general practitioners are first and foremost renowned as problem solvers. It is always interesting to see what one's predecessors have done. One can ask one's friends and family for advice or seek inspiration in the writings of others.

I decided that if I were worthy of being President then surely I must have something interesting to say for myself. So far as I could see the President of the Ulster Medical Society has carte blanche in this matter. At this point, my mother's words came into my mind. As a teacher she was fond of quoting from Hamlet:[1]

> "This above all: to thine own self be true,
> And it must follow, as the night the day,
> Thou canst not then be false to any man."

So, the society has an ordinary jobbing general practitioner for President this year. General practitioners as a group are not noted for the scientific rigour of their work or speech. But they are very good at anecdotes, and anecdotal evidence is perfectly valid so long as it is recognised as such. My talk on this occasion is in the manner of an autobiography, from and with which I hope to demonstrate some of the ways in which general practice has changed over the past half-century and to show how it might develop in the future.

To me, one of the pleasing things about general practice is the way in which the academic and practical aspects are as intertwined as the Yin and the Yang.[2] You will already have recognised this as my second allusion to Chinese culture, the first being in my title which refers to an ancient curse, "May you live in interesting times!" One aspect of this intermingling has been beautifully illustrated in his book" "The Doctor, Father figure or Plumber" by Dr James McCormack from Dublin.[3]

For Yin and Yang one might also substitute Royal College of General Practitioners and General Medical Services Committee. The College attempts to promote the academic and ethical aspects of general practice while the GMSC is mainly concerned with matters of regulation and pay. The College does however clearly recognise a balance between these elements[4] though their diagram is not as elegant as the Chinese one, and they would never be so indelicate as to mention money, although, like medical ethics, this is one of the engines which drives doctors.

The College recognises the new conflicts which have arisen in the National Health Service after the reorganization of 1990. It refers in its Report from General Practice number 27[4] to the development of a two-tier structure in the delivery of secondary care for patients and perceives the dangers of the shift in the responsibility for rationing of care from administrators and politicians towards doctors. Remember that this is the College which 25 years ago promoted Dr John Fry's paradigm where patient need is always greater than demand which in turn is always greater than resources.[5]

IN THE BEGINNING

'Where shall I begin, please your Majesty?' he asked. 'Begin at the beginning,' the King said, gravely, 'and go on till you come to the end: then stop.'[6]

In the beginning, my father was a doctor. I was born just after the Battle of Britain and my first memories of him were at the Garlands Hospital, Carlisle, the County Psychiatric Hospital for Cumberland, where he worked as a junior hospital doctor under the superintendent, Dr Madill, who also was an Ulsterman. Following some

experience in general practice in South Wales in the 1930's which by his account was very similar to that described in A J Cronin's novel "The Citadel",[7] my father had decided to become a general practitioner. However he was trapped in hospital work by the war, as in addition to his normal psychiatric work he supported an Emergency Medical Service Hospital for sick and wounded soldiers and prisoners of war.

After the war my father bought a practice in a mining village in County Durham called Trimdon. We moved there in 1946 which was a major culture shock to us all. The practice had been allowed to run down by the previous doctor who had been what would now be described as a Sick Doctor. He had died about half-way through the War. Fortunately the practice had engaged the services of a young Irish doctor who had kept things going as an assistant. One of my father's first and best decisions was to keep him on and he quickly became a partner.

The practice numbers grew and eventually another partner was taken on. Each partner consulted in his own house, looking after his own patient list although they did combine to allow each other some time off duty. The actual consulting and waiting rooms were very good as they had been purpose built by the previous doctor. Notes were kept in the traditional Lloyd George envelopes and filed in metal cabinets as they still are today in some practices. There were no receptionists and the doctors carried out some dispensing of medicines. There was however a retail pharmacy in the village and I remember my father saying that he preferred the chemist to dispense medicines as he considered that this was not really his job.

By today's standards there was very little professional contact between the partners. Patients usually came to the surgery on foot in order to see the doctor or to leave a message requesting a home visit. Only a very few private patients ever came to the front door! It was necessary for everyone to listen for the door bell and the telephone as these might ring at any time all 365 days of the year. Patients might arrive at the door in a collapsed state or with blood pouring from a wound and my mother was obliged to tend to their needs as best she could until my father came home from his rounds. In the early days he was summoned to accidents underground in the pit, and his patients greatly appreciated his attending them there.

For some years my father cared for an elderly sick doctor who lived in a nearby village. He also looked after his small list of patients. I know that he received no money for this work as my mother did not approve. Nevertheless, my father considered that he had an ethical duty towards a colleague who had fallen on hard times which encompassed both clinical and social needs and which transcended any purely financial aspects. He may also have reasonably expected to inherit the list of patients!

My father always enjoyed meeting his partners and soon like General Practitioners everywhere they were discussing their patients in an animated manner but they had no formal clinical meetings at all. Relationships were always formal and they addressed each other by title and surname. Initially they practised on their own without support from receptionists or nurses and midwives and they had much more contact with the local clergy than with clinical colleagues.

Holiday locums were a problem. One doctor could not do the work of two and it was necessary to ring the Secretary of the Student's Union at Queen's University from time to time to find an unemployed Irish doctor who could stand in for a month or so. Some of these locums were notable characters, rather fond of the bottle and on one occasion addicted to narcotics although this did not come to light in Trimdon and we had no disasters that I am aware of. Indeed my father and his partner were asked by the General Medical Council to supervise this last doctor's eventual re-introduction to clinical work. This they agreed to do regarding it as a difficult but honourable professional duty. On one other occasion a locum developed poliomyelitis and was nursed in our house by my mother for some weeks until he recovered.

In 1948 the appointed day dawned and the National Health Service arrived. I learnt later that this had been opposed by a significant proportion of the medical profession and that Aneurin Bevan had 'stuffed the consultants' mouths with gold'[9] to get it started. I remember that for the first time the whole population was encouraged to register with a general practitioner. This did not make much difference to my father as most of the village was already on his 'panel' as was the right of all working folk and their families. He did however lose his small number of private patients. I also remember my aunt, a general practitioner in

Chesterfield, saying how good it felt not to have to worry about bad debts anymore! My father complained bitterly at that time about the number of prescriptions which his patients were requesting. They had been encouraged by the government to regard the new NHS as being able and willing to supply anything they asked for. The were therefore unsuccessfully requesting endless supplies of codliver oil and cotton wool for nonmedical uses such as caring for their greyhounds.

The response of general practitioners to this trauma lay somewhere between two extremes. One was to drop dead in harness and the other was to join the new College of General Practitioners. My father at this juncture decided to employ a receptionist and claimed that it transformed his professional life for the better. I remember the angst of the Dankwerts Award,[10] which significantly increased general practitioners' pay.

I recall the drama of sending to the BMA undated resignations from the NHS that my Father, two Uncles and an Aunt submitted when Dr Jim Cameron of the GMSC was negotiating with the Government in the 1960's to produce the GPs' Charter[11] which gave us reimbursements for our staff and premises, and encouraged us to work together in partnerships.

I never wanted to be anything but a doctor. I did not seriously consider any medical school other than Queen's even though I was the first student to apply to Durham Education Committee for a grant to study there.

In the days before the Todd Report[12] on medical undergraduate education was published, the aim of a medical school was to produce a "safe doctor." This meant that students were not expected to develop problem-solving skills but were required to learn a great mass of fact, much of which was expected to last them for the rest of their professional lives. In those days students rightly feared that if they did not reproduce exactly what their lecturers had said they might well fail their exams and perhaps never qualify. There were still a few perennial students around the medical school who might take decades before acquiring their final degrees, if they ever did so. The pre-registration year was however well established though it was perfectly possible to enter general practice immediately upon its completion.

My own entry to general practice was in exactly this manner. I had decided to become a physician and firstly to proceed to an MD in pathology. At that time clinical medicine was still largely based upon cellular pathology and it was common for aspiring physicians and surgeons to spend time in pathology before returning to clinical work. The post in histopathology was not available until October, so after my houseman's year I had two months to put in which I decided to fill by doing GP locums. Accordingly, I finished work as a Houseman at the Royal Victoria Hospital on July 31st and took over a large single-handed practice in Holywood on the following day.

EXPERIENCE OF GENERAL PRACTICE

The single-handed practitioner whom I was replacing was in County Cork. I was left in sole possession of the practice and surgery, where I resided. This was necessary as there was no answering service or on-call rota. There was one invaluable asset which he left behind, his housekeeper. 'Don't worry' he said on the phone before he left, 'she knows everything. If you get stuck ask Nora.' He added cryptically 'the chemists are very helpful.'

I soon discovered what he meant. Much of the set-up was familiar from home. The morning surgery began at 9-30 am. Notes were kept in the consulting room and were taken out by the doctor whenever he felt the need to do so. As far as I could see this was not at every consultation! Hospital letters were carefully filed away though judging from their pristine condition they were usually then left in peace. The daily post often consisted of two or three hospital letters which were read in the dining room over toast and marmalade. There were no letters from Voluntary Agencies, Social Services, Physiotherapy, Occupational Therapy, Speech Therapy, Chiropody or Audiology and I remember no requests for legal reports. There were a few letters from the Medical Referee Service but none from the various welfare agencies which have proliferated since. I cannot remember being asked to complete a single report or questionnaire during the happy month I spent there.

The patients were the usual mixture of diagnostic bewilderment and professional frustration. Like my first day at school I still remember much of my first day as a general practitioner. This has been better described by Keith Hodgkin in his autobiography.[13] Suffice to say on later reading his book I empathised fully with his bewilderment in having to cope with new syndromes such as

'dizzy spells in the busy spells.' I also found the pharmacopoeia rather confusing. I had been well grounded in how to treat common medical conditions by Professors Wade & Elmes but I knew almost nothing about tonics. This was where the local chemists came in so handy. I had not finished my first surgery before they were on the phone to explain the finer points of phenobarbitone & theobromine mixture.

Frankly even with their help, I could not then and cannot now understand some of the repeat dermatological prescriptions which were at that time issued by consultants to private patients. No variation from the ancient formula could be tolerated. Each ointment was made up from the recipe written in copperplate pen and ink on a scrap of shrivelled rice paper and I never became initiated into the mysteries of minims and drachmae.

At the same time life and death proceeded as they always do. As T. S. Eliot[14] would have it–

> "That's all the facts when you come to brass tacks,
> Birth, and copulation, and death."

I gave antenatal and terminal care. I comforted the distraught and dealt with medical emergencies as best I could. I remember doing no preventive work at all. I puzzled over crying babies, I still do, and discovered new diagnoses like 'teething' which still come in handy. I recall one Old Wife when she and I held a joint consultation over a coryzal child. 'Why don't you give him achromycin?' she asked. 'Why should I do that? I responded 'Well' she said 'if you give him achromycin he will boke it all up and that will get rid of the phlegm and then he will feel better.' This was the sort of practical lesson in therapeutics which even Peter Elmes never imagined. In her defence, should she need it, I must say that at that time had the infant been seen at the local paediatric unit, achromycin is exactly what he would have been given! I wrote death certificates and referred patients as required. I took a crash course in local geography which is still useful at times. Looking back I do not think I did too much harm. The principal must have thought so too as he was good enough to invite me back to repeat the process the following year.

After three years in histopathology interspersed with locum work, I finally had to decide which career to follow. I had discovered the joys of being a generalist and did not want to give them up. I felt that there would be more opportunities to express myself in general practice which seemed to me then as it does now, to offer almost infinite scope for development and change. When I imparted this news to my pathological colleagues I was struck by the fact that only Professor John Henry Biggart showed no surprise. He asked what practice I intended to join. When I told him he sucked reflectively on his pipe. 'Yes' he mused 'that's a well-run practice'. I have always regarded this as a form of paternal blessing.

My new practice was a Training Practice and although I did not do vocation training which had recently been set up on a voluntary basis, I was fortunate to receive almost the same thing, as my appointment as an assistant for 11 months coincided almost exactly with the appointment of the first trainee to the practice. I was permitted to attend tutorials and other classes with him from which I greatly benefited. Indeed I consider that I had de facto vocational training and owe a great debt of gratitude to my trainer and her colleagues. She was certainly capable of taking my breath away with a vengeance. Knowing of my pathological background she began by asking me about the histopathology of Neimann-Pick Disease. Later when de-briefing me following a home visit she asked me what I had thought of the sick child's father. Did I consider him a forceful character? I agreed that he probably was. 'Yes' she said, 'that's the second marriage, you know. He was so nasty to his first wife that she got Crohn's Disease and died!'

With this sort of background Balint[15] made sense. I soon became involved with the nascent department of general practice and took students for teaching. I became interested in Vocational Training for General Practice and became a trainer. At that time the practice ran surgeries six and a half days a week and evening surgeries often ran on past 7 or 8 pm. We used no locums for holiday or sickness cover though I was fascinated to discover that the practice had formerly employed a young physician in that capacity who was later to rise to professorial rank. The partners had some interesting and not disrespectful comments to make about him but agreed that he would never have succeeded in general practice.

I discovered that it was normal for experienced practitioners to discuss their professional

problems together and even confess to ignorance although there was debate about whether one should ever admit this to a patient. The partners had other very interesting views about specialists. Consultants were loosely classified into a number of categories. These were useful or not useful, accessible or inaccessible, industrious or lazy. They were certainly not regarded as infallible and the partners felt that after a few years experience they could decide what a new consultant was good for.

My partners agreed that the then current fashion for prescribing benzodiazepines on each and every pretext was both misguided and harmful. This, remember, was at least a decade before such doubts surfaced widely in the medical literature.[17] They described their role in supporting the neurotic and chronically ill as 'keeping them going' and regarded early diagnosis of life-threatening disease as a major priority. They prized medical nous above almost all else and the greatest compliment they could pay was to describe a fellow practitioner as "shrewd." After seven years in this practice I was appointed to the post of Senior Lecturer in General Practice at Queen's University, Belfast.

ACADEMIC LIFE

The department of general practice had developed as an off-shoot from the department of social medicine. By the time of my appointment it had detached itself and found a home in the then new Whitla Medical Building. There on the first floor it was sited between Psychiatry and Oncology a situation which I felt to be appropriate both literally and figuratively.

My teaching and clinical duties were not onerous and my time was relatively unstructured. I was fortunate to work with Drs Ben Moran and Jack McCluggage in the GP Trainee day release course which then covered all of the province. I found myself working as a general practitioner in a number of practices in South and in West Belfast which was a useful extension to my professional education. I discovered that it was very difficult to change practices. One's old patients were angry at what they perceived as rejection and it was difficult to establish new professional relationships when one was changing practices so often. My problem was that while I had the authority I had not the power of an established general practitioner. As Professor Paul Freeling of the Department of General Practice, St George's Medical School, London has said. 'Authority comes with the white coat. Power is what the individual patient gives you.[18]

I had no direct patient base on which to perform the clinical research that I wanted to do but I did have access to general practice all over the Province through medical undergraduates and trainees. I therefore extended the existing Log Diary which students kept while out in practice.[19] Medical students can make very accurate and reliable observations in general practice as they are not directly involved in the process. Trainers and trainees likewise were able to complete log diaries for me and I processed all of this information in the central University mainframe computer. The drawback to this was that I needed help to input and interpret the data which I'm sure nowadays would be handled at the desk by a PC. However it was analysed using Statistical Packages for Social Sciences[20] which I believe are still used and I hope that this material may become a useful archive within the Department of General Practice.

Among the studies I wrote up at this time were analyses of the different clinical material seen by trainees and trainers. I was interested in how to distinguish between good and bad trainees. This I did by looking at the clinical behaviour of trainees who later passed the MRCGP examination compared with the clinical behaviour of trainees who did not. I felt that I could identify significant differences between the two. Even more interestingly I felt I could show equivalent differences in the clinical performance of their respective groups of trainers.

Influenced by my work as an examiner for the Royal College of General Practitioners I became interested in the question of attitudes. The process of learning can be divided into three domains called cognitive, psychomotor and affective or, in plain language, knowledge, skills and attitudes. I became fascinated by the complexities and ambiguities of assessing and defining attitudes and how these in turn affect a doctor's clinical behaviour which they undoubtedly do.

Accepting that doctors as a group were/are highly analytical and intelligent and knowing of the strong psychological forces which make us all tend to behave "politically correctly" I decided to work with a system which would be impenetrable to the doctor being assessed. My advisers in psychology told me that such a system existed in

the form of the Semantic Differential based on the work of Charles E Osgood of the University of Illinois.[21]

The application of this work was mathematically very complex and involved factor analysis using a good deal of computer power. I constructed test papers of 20 parameters using topics which I selected on the grounds that they would be of interest to all practising doctors. The exact nature of the topics did not matter as I was only interested in grouping the scores of individuals from different medical disciplines so that I could then define the core attitudes found in each medical discipline. I wanted to establish a data bank of information which would allow me to assess the attitudes of an individual doctor in order to assign him or her to an appropriate medical discipline.

I was reasonable successful in getting experienced colleagues to complete these papers though about 10% showed their apprehension and confusion in the letters which they returned with their scores. I was able to establish a database to my own satisfaction and began to compare the scores of random individuals in order to assign them to a particular medical discipline. This was modestly successful. I had hopes of testing all final year medical students in order to compare their scores with their eventual career choices when disaster struck. My mathematician took a better post in Dublin and I was unable to replace him!

MY OWN PRACTICE

Becoming frustrated by my nomadic clinical existence, I decided with some reluctance to leave academia and return to full-time service general practice. A single handed practice became available in East Belfast and I was appointed to my present post on lst May 1980.

The practice has grown through two changes of address now to include three partners. From an early stage the practice has been interested in Audit and has produced an annual report since the mid 1980's. As it is difficult to define hard end-points in general practice I decided to use death as the hardest end-point of all. Our death audit has been useful in comparing the practice death rates with those over Northern Ireland as a whole. It seems to show some relative improvement in patient mortality with the passage of time which we like to think reflects the hard work of the whole practice team.

We embraced Fundholding[22] as soon as we could, joining the second wave of fundholding practices in 1994. We have found the experience interesting and productive though hard work for all concerned. It definitely can give better services for patients. Some of the by-products of fundholding are fascinating and clearly indicate areas for future research with regard to capitation funding and the organisation of a primary care led health service.

The New Contract,[3] like the curate's egg, was good in parts. General Practitioners by the very nature of their daily work are accustomed to accepting all of life's inequalities and unfairness, and will always try to make the best of a bad job almost as a professional reflex. The new contract was accepted by general practitioners both for this reason and because of lack of leadership from within the profession. In 1990 I felt that it could not be allowed to continue unmodified but what was to be done? Things that are only good in parts are essentially bad. "It is necessary only for the good man to do nothing for evil to triumph" said Edmund Burke.[24] Just as, according to Georges Clemenceau, "la guerre, c'est une chose trop grave pour la confier a des militaires", [25] I decided that medical politics was much too important to be left to the medical politicians. One almost felt sorry for Kenneth Clark, the Secretary of State for Health, in having to deal with a group of doctors who, like the Bourbons of old, forgot nothing and never learnt anything and whose only ambition was to keep things exactly as they had been, which was in fact the only objective which was completely unattainable.

I decided to throw my hat into the ring and was elected to the Eastern Local Medical Committee (ELMC) in 1992. This was not too difficult. I was elected unopposed. I decided that it was necessary to politicise my colleagues and to this end have circulated a Newsletter for the past four years to all the 420 or so GP Principals in the Eastern Board Area. One of the things I have encouraged is the collaboration of general practitioners in co-operatives for out of hours care.

Out of hours co-operatives have been set up in three of the four local areas covered by the Eastern Health Board. This has already transformed for the better the social and family lives of the doctors involved.

This work has led to my becoming involved in the ELMC/EHSSB forum on commissioning of care

from Health Trusts. The Health Boards commission from Health Trusts all of the health care received by patients of non-fundholding general practitioners from health trusts and about 70% of the care received by patients of fundholding general practitioners. The Eastern Health Board has established a "forum" where general practitioners representing their colleagues from the four community health districts within the Board area, meet with Board officials to plan and arrange contracts with Trusts for patient health care.

We may well be poised on the brink of major changes in the commissioning of patient care. We must work towards the development of a true primary care led Health Service in order to maximise the resources available for health care, and to deliver the best service possible to our patients. This will require a great deal of research and development which needs to be funded. This has not yet happened in Northern Ireland although it is beginning in other parts of the UK. We also need funding to support the changes in medical undergraduate education implicit in the "New Curriculum"[27] which is much more primary care based. This will necessarily involve a major redirection of teaching and research resources from specialists to generalists in the community. The implications of the Calman Report[28] on specialist education will also impinge upon general practice in a major way involving day to day clinical care.

Doctors are only human and may err. Through the Local Medical Committee I have become involved in the problems of "Sick Doctors". This is of course a euphemism for doctors incapacitated by abuse of alcohol and/or drugs. These individuals may present at any stage from studenthood to retirement.

However, when in practice, they need to be identified and removed from practice if patient care seems to be in jeopardy. We may facilitate this process by reducing the financial burden of "outing" for these individuals. The resulting threat to their income may prevent some families from disclosing the truth and some doctors may forget that their first ethical responsibility in this situation is towards care of patients and not the protection of a colleague and their family.

Whatever else the future holds I am sure that like the past it will not be boring. The one constant in all this flux seems to be the wants and needs of the patient who will, it seems, always desire to consult the doctor in whatever fashion is prevalent at the time.

ACKNOWLEDGEMENTS

I wish to thank all of my colleagues for their help and support. I am particularly grateful to Dr Kathleen Herron, my first Senior Partner and to her colleagues at the time who showed great patience when their practice was invaded by a proto-academic. I must also thank the members of the Department of General Practice at Queen's University for showing me the academic ropes. Dr Noel Wright, Adviser on General Practice, then Secretary to the Northern Ireland Council for Postgraduate Medical Education, was supportive in difficult times. My present partners especially Dr Ann Little have allowed me to follow my own bent, and I have always known that I could rely on the support and encouragement of my family especially my wife Catherine.

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