

Welcome!

In this edition you'll find an interview with busy Zoe Goodman from Leeds; a travelogue from Mary Bratton who spends half her life in Wales and the other half in Western Australia; Judith Harvey takes a look at literature and medicine; Jason Twinn gets suitably heated about methadone prescribing and a whole load of other Sessional GPs give a rundown of their local groups. Plus news affecting us all from the GMC and a nifty little download from the NASGP website.

Time for Freelancers to get Organised

The General Medical Council thinks it has a problem. It has been told by The Shipman Enquiry that it has to be seen to be making sure that every GP can provide hard evidence that they're working within a low-risk environment – you know the sort of thing: a robust process of appraisal, quality feedback relating to clinical practice, working in a team environment, clinical and professional support etc. And without actually saying so, the finger is being pointed directly at Freelance GPs. Quite right too – on the whole, working as Freelance GPs, it is very difficult to find work in a low-risk environment. Indeed, working in high-risk environments is one of the things we do – in overworked practices that have made the absent incumbents ill; deprived practices that can't attract a regular GP; in disorganised practices that leave things till the last minute...you get the picture.

(continued p2)

Outback Dreaming: Freelancing Frontier Style

It is said that those who come to the remote northwest of Western Australia are one of the "three M's" - mercenary, missionary or mad. The "fourth M", Sessional GP Mary Bratton, helps to dispel this myth.

I first began working for the AMA (Australian Medical Association (WA)) 7 years ago, after coming over to Australia from the UK where I had been doing sessional work for a GP practice in South Wales and a rural practice in North Wales. Having never been to the Australian outback before, let alone worked in an isolated medical setting, I approached WACCRM (Western Australian Centre for Remote and Rural Medicine) about doing remote work in Western Australia (WA) as an "overseas" doctor, and have returned there each year since; I work for the other part of the year back here in the UK in Snowdonia National Park.

Most of my work has been in the northern Kimberley and Pilbara regions of WA, in hospitals providing GP services, in aboriginal communities and for the Aboriginal Medical Services. In spite of the problems of distance, weather, and various language and cultural factors such as the traditional Aboriginal model of illness causation emphasising social and spiritual dysfunction as a cause of illness, with supernatural intervention being regarded as the main cause of serious illness, there is considerable scope to investigate and "manage" patients which I have otherwise often found limited in NHS practice. I can recall recently seeing a 36 year old woman who popped into a remote aboriginal community clinic at the end of the day, after returning from a family visit some 400 kms away. She mentioned to the nurse that she had suffered with some chest pain which she thought might be like the problem shared by other family members. I was able to fax the grossly abnormal ECG to a cardiologist in Perth and arrange "immediate" admission to a Perth hospital (after an 8 hr flight with the Royal Flying Doctor Service!). The daily frustrations of dealing with the chronic conditions

that underlie such a scenario form a constant counterpoint to the idea of medical treatment as an end in itself.

The locum placements that I have chosen are based on my travelling instincts and have been relatively short term, though I know or have met many doctors working in the northwest who prefer to stay in one place in Regional Hospitals, where there is ample scope for those who want to do "procedural" general practice – with anaesthetics, obstetrics and gynaecology etc. Although it can be logistically difficult to connect patients with visiting specialists (who come relatively infrequently) I have found that, where things are followed through there is probably more chance of seeing specialists within a reasonable time than in parts of the NHS or in cities in the southern parts of Western Australia. This is the kind of paradox that applies to the under-populated northern parts in general. For instance, how do you advise patients who are sitting targets for early diabetes and heart disease to eat fresh fruit and vegetables when these arrive once a week in a refrigerated truck from the capital, Perth, hundreds of miles away?

The more affluent parts of West Australia, closer to Perth (once famed for having more restaurants per head than anywhere else in the world), offer a stark contrast to the remote regions of the north. Its cosmopolitan city centre, huge hospitals, famous windsurfing beaches and the spectacular wine producing region of Margaret River can provide a welcome balance to periods of relative isolation. But it is this isolation, combined with the huge blue skies and everywhere the 'pindan' redness of the earth; with the changing colours of the cliffs of Broome at sunset, the gorges of Karajini National Park or the hills around Hall's Creek; the overwhelming heat of the desert, even with the roads being cut off for days, weeks or longer; the raw unbridled power of the outback - that's the attraction for me.

Mary Bratton



Ten Top Tax Tips for Freelancer GPs

Whilst being a Freelance GP gives you a freedom from running a large practice, you are still a business, which means ensuring you comply with all the accompanying red tape.

Here are some of the tax and national insurance points that you need to consider:

- When you first start you need to register as self-employed with the Inland Revenue and arrange to pay Class 2 National Insurance contributions. There is a £100 penalty for failing to notify within 3 months of starting.
- If your projected net earnings are less than £4,345 p.a. consider obtaining exception from Class 2.
- If you are also employed and paying Class 1 National Insurance, consider obtaining deferment of Class 2 and 4 National Insurance contributions.
- Keep appropriate records – failing to keep records can attract a fine of up to £3,000 (and more if failure continues).
- Records do not need to be elaborate – a simple spreadsheet recording income and expenses, backed up by invoices and receipts, may be all you need. Consider a separate bank account and credit card account just for business items - this will make it easier to collate the information.
- Keep a mileage log – for at least one month, or if your journeys vary considerably, permanently – so that you can

Time for Freelancers to get Organised (cont. from front cover)

Now, spending a few seconds thinking about it, the obvious solution would be to reduce this risk, i.e. provide support for Freelancers, by creating the possibility for managed organisations within which they can work, with CPD, appraisal, clinical governance all built-in. In fact, exactly what we suggested 3 years ago when NASGP created the Sessional GP Support Team concept, www.nasgp.org.uk/sgpst.

But rather than this straightforward, creative and proactive way of managing risk to patients, what have the GMS suggested? Yep, you guessed it: bureaucracy. They don't want to manage risk, they want to measure it! What are they like? Naturally, we've told them what we think of this idea and what they really ought to be doing. At this stage of the game we all still have the choice, but it won't be easy. We will all, sooner or later, have to be working within a managed organisation, whether it be PCT based, a 'chambers', a conventional practice or a private company. The GMC has the power to make life very difficult for individuals who isolate themselves professionally. Team up, chaps.

justify the business miles claimed. If your gross fees are less than £60,000 p.a. you can just use the approved Inland Revenue mileage rate of 40p for the first 10,000 business miles (and 25p per mile for any subsequent mileage), rather than having to total up all your individual car expenses.

- Similarly keep an eye on telephone usage – splitting it between personal and business. If you can show how you have arrived at the apportionment, rather than just guessing, there should be no problem obtaining the tax deduction.
- Save for tax as you go – don't leave it until the payment is nearly due.
- Consider using a specialist accountant from day one – they will be able to provide you with checklists of expenses that you can claim, tell you how much tax to save and deal with all the set-up work for you, so that you can spend your time earning money! Ask them for a fixed fee – to include phone calls – so that you can approach them when necessary without wondering what it will cost.
- Provide your accountant with information promptly – the earlier you give it to them, the earlier they can warn you accurately about tax liabilities.
- Always be totally honest with your accountant. Money Laundering Rules mean that all accountants have a legal responsibility to report any tax evasion they suspect, however small, or face criminal charges themselves. A good accountant will ensure that you always pay the minimum tax legally required.
- Remember to ask for advice before acting, rather than afterwards when it will be too late to change how something is done.
- Some recent examples we have come across where a quick phone call would have saved large amounts of tax:
 - Buying an expensive computer the day after the end of the accounting year – meant that the tax relief was delayed by a year.
 - Owning two houses and selling one – not having made the right election for main residence hugely increased the tax bill.
 - Not understanding the allocation rules for shares, they were sold and repurchased too close together to create the intended capital loss – so no tax relief, just the unnecessary costs of the transaction.
- Finally, remember that you are your business – if you do not work, no money comes in. Make sure that you have appropriate life cover, critical illness cover, sickness and accident insurance etc.

Liz Densley is medical specialist partner with Sussex Chartered Accountants, Honey Barrett and secretary of AISMA (the Association of Independent Specialist Medical Accountants). Contact her on 01424 730345 or at liz.densley@honeybarrett.co.uk. www.nasgp.org.uk/money



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SABBATICALS ON OFFER IN AUSTRALIA.

The Australian Medical Association (AMA) is seeking to contract General Practitioners or Specialists with UK or equivalent qualifications to work in various locations in Australia, for periods of 6 to 12 months from August 2005. Applicants selected will be sponsored through Immigration by the AMA. Doctors interested should make application to Ms Nicky Sjepcevic by email to: recruit@amawa.com.au



Twinn Speaks



Jason Twinn, NASGP member and regular contributor to the www.doctors.net.uk 'non-principals discussion forum', continues his regular column giving a round-up of the latest hot issues being debated.

As a GP principal I had a policy of not prescribing methadone – ever – and in conjunction with my partners this policy worked well: all prescriptions were done by the specialist team. But now, flitting from one practice to the next, I come across practices where methadone is prescribed and where patients turn up expecting their prescription from me. By the thread in the doctors.net.uk forum this month, it appears I am not the only one who encounters the problem and thankfully it appears I am not the only one to take the stance I do.

Not being an authority on methadone and generally not knowing the patients, I take the view that it is not safe for me to prescribe the drug. In my opinion several factors need to exist before it is safe for a GP to issue a prescription. One is knowledge – of the patient and of the use of methadone. Secondly, trust is required – in the form of a relationship between patient and doctor with regular drug screens to ensure that the prescription is not being supplemented, and lastly is agreement – between the prescriber and the patient – in the form of a contract. In most areas of general practice the safest, easiest and most productive way to work, again in my opinion, is with well defined boundaries – this might be in relation to letters on housing, intervals between repeat prescriptions, but nowhere is it more important than methadone prescribing. It's not that the addicts are scheming and will take a mile where you give an inch, oh no, it's that the heroin turns them into the most manipulative, slippery customers known to man.

But even worse is when one of these patients turn up in the middle of an empty surgery and you have to bounce your one patient - amid a sea of empty appointments - back to the partners. It does happen though, as others' experiences (and my own) on the forum will testify; going to a practice, and either because it is an advanced access practice that has plenty of spare capacity for the day, or for whatever reason, you find yourself twiddling your thumbs, spending your "hard earned" cash on eBay or Amazon faster than you are earning it. Should you feel guilty, should you look for other work, should you offer a reduced rate in retrospect? The simple answer to all these questions seems to be no. Whether you choose to do any of these is of course entirely up to you.

Of course you might be looking to become a partner – what should parity terms be? Naturally this is a matter purely on an individual basis between the potential partner and the existing partners, but in the past – and I mean only a year or so ago – there was the attitude that straight into parity should be the norm unless you were lucky enough to land a very competitive post and were not in such a strong negotiating position. In the past, throughput was the name of the game and, as long as you saw your fair share of the punters day to day and signed your prescriptions and so on, then you may well have been contributing equally to the workload. Now, however, with all the effort that will have gone on with the new contract to set up systems, protocols and preparation work, coupled with the fact that practices now are free to employ salaried doctors and nurses to do a lot of the work which was previously done by a partner (resulting in fewer vacancies being advertised as partnerships), the orbit of change is revolving and perhaps we should not expect quite such favourable terms when joining a practice. Don't of course forget the golden rules of negotiating – not least aim high with your opening bid!

You can contact Jason at j.twinn@doctors.org.uk

In response to the previous edition of the Sessional GP, in which Twinn Speaks questions the RCGPs' toughened stance on ex-college members using the 'MRCGP' postnominals, previous RCGP Membership Officer Dr Tina Ambury FRCGP explains their reasons:

"Whilst I was Membership Officer of the College we were contacted by the MDDUS regarding one of their members who had been involved in giving evidence in the GMC hearing of another GP. That GP levelled the accusation that their member was using MRCGP improperly – presumably with the implication of dishonesty and throwing doubt on his integrity. The member was doing no such thing; like Jason he had merely cited his passing the exam, not an ongoing relationship with the College. The GMC took the accusation seriously and investigated it, finally accepting the exam pass explanation – one we at the College fully endorsed. The GMC line was that anyone using the postnominals signified an ongoing membership of the College which the public viewed as an endorsement, and therefore using them inappropriately would be viewed in a very dim light as potentially misleading the public."

South Essex Sessional GPs Support Group

We're currently working with our PCT and LMC to come up with a realistic salary structure for salaried GPs, and we hope to have this finalised soon.

We've just had a meeting focused on erectile dysfunction and its treatment, and are planning a diabetes update and a talk on recent developments in the treatment of hypertension.

Invitation to our meetings is extended to all like-minded GPs.

Parameswaraiyer Ambikapathy aonedoctor@hotmail.com

Mid Sussex Sessional GP Group

14 members of the group attended the latest drug-sponsored meeting, with each receiving a certificate of attendance. We had a talk from our local PCT on our Drug Formulary. The formulary has been adopted by several practices and is based on the BNF Chapters and gives suggestions for first, second and third line drugs plus OTC preparations in all the areas of prescribing. The list is suggestive and other formulations can be used at the prescriber's discretion. We also produce a local Newsletter for Sessional GPs. Our next meeting will be the Christmas Meeting, with no speaker, on Thursday 8th December.

Howard Bloom howiebloom@aol.com

Sessional GPs of Swindon and Cirencester

Our group now numbers about 50, of whom 15 met up last night for a curry to say thank you and goodbye to Laura Patterson who has been running the group for the last few years. The meal was a great success and it was good to meet up with everyone after the summer break. In fact Laura enjoyed it so much that we have agreed to give her honorary

membership of the group, despite her now being a partner!

The database of all our email addresses has now been supplied to the local postgraduate centre and various other sources of meetings locally, which means that we are all sent details of most of the educational meetings being held nearby. I hope this will mean that we will now have access to much the same information on meetings as the local GP principals.

We have a meeting planned for 19th October on appraisals - a question and answer session with a buffet meal beforehand - and may manage an ENT update with the new ENT consultant at GWH before Christmas.

Alison Brooks acbrooks@btinternet.com

East Sussex, Brighton and Hove Sessional GPs

We have a large group of 60 sessional GPs with three smaller learning sets each containing 12 - 15 GPs.

By and large, the local learning sets set their own agenda around appraisal. This comprises group audits, looking at critical incidents, discussion of PUNs and DENs, and collating feedback from patients and colleagues.

The quarterly East Sussex-wide group functions more as a network for meeting other sessional GPs and there is a speaker on a topic of interest. The October meeting is on Palliative Care in the primary care setting and will be led by Dr. Crista Beesley, a local GP with a keen interest in this area who is also involved in a national initiative looking at standards of palliative care in nursing home settings.

Some GPs haven't yet heard about their next appraisal, while others are in the process of collating info, looking at last year's objectives (and wondering where the time to achieve them has gone). There is lots of local interest from an increasing number of sessional GPs looking to join learning sets.

We have approached the Deanery to seek additional funding but there is none available. Members of the existing local learning sets have each therefore agreed to make a contribution so that other learning sets can be set up.

Tom Scanlon tom.scanlon@bhcpct.nhs.uk

Morecambe Bay Non-Principals

I am pleased to report that our first journal club was a success, with 10 people attending including 4 who have just finished their registrar year. We met at the Education Centre in Kendal which is fairly central and easy to book.

We discussed a range of topics, although 3 people did choose the same article on headlice from the BMJ - obviously a subject dear to the hearts of GPs! We also covered alternative treatments to HRT, new missed pill advice, a guide to medication reviews, URTIs and non use of antibiotics with thoughts on trimethoprim being available OTC.

We considered what format to have for future meetings and ideas of who we could invite. There was also some discussion about the local locum bank

which has not been functioning well recently, so we will lobby the PCT to try and rejuvenate it.

Rowena Grenfell all@thebrownefamily.com

Sefton Non-Principals Group

The group has 40 members, of which the normal attendance is about 20. The group meets every 2 months in a local restaurant. We had a meeting on 7th September and the speakers were from the local Mental Health Team. They made a presentation on the new common pathway for referral to psychiatric services. Our group has representation at the LMC. Initially, they asked for a levy to an amount of nearly £500. We have declined to subscribe to this demand. The Appraisal System is working well and we are being paid.

Nick Pati dr.pati@virgin.net

Essex Sessional GP Team

We were established in January 2004 to provide support to all sessional GPs in Essex. The team consists of two sessional GP tutors and a full-time manager. We offer support and assistance to Essex sessional GPs in terms of career advice, personal development, the administration of and training in appraisal, and improved communication between the doctors and the relevant parts of the NHS. The key component of our role is the closer integration of sessional GPs into the NHS in Essex.

Over the last year and a half we have worked hard to establish exactly who is working as a sessional GP in Essex and to ensure that they are all provided with regular newsletters, educational mailings and assistance with preparing for their first, and now in some cases, their second GP appraisal. We are also assisting sessional GPs to set up local self-directed learning groups.

We recently held the first ever 'Sessional GP Day' in Essex. This provided an opportunity for sessional GPs all over Essex to get together and attend a day of sessions aimed specifically at them.

The day began with an update on pensions, followed by two talks by Richard Fieldhouse; the first on his locum chambers and the second on the NASGP and what it can offer sessional GPs. We ended the day with a career fayre, where various local sessional GPs gave short talks on roles they do within and in addition to their work in general practice, such as working as a police surgeon and on the Flexible Career Scheme, and invited representation from the LMC and local PCOs.

The day was well evaluated and we are very keen to run more days in the near future!

Sarah Powell sarah.powell@essex.nhs.uk

Excellent Superannuation Forms

Bored of filling in those silly tedious pension forms? Just know there has to be a better way? There is! We've developed a simple Microsoft Excel spreadsheet for members to download from our website at www.nasgp.org.uk/superannuation.

Enter all the data on your PC and the columns automatically calculate your payments. Simply print out on to a blank sheet of paper and, hey-presto, a rather smart superannuation form. Strictly speaking, these are the England/Wales forms, although the data you provide for Scottish practices is the same so we suggest you give this spreadsheet a go in Scotland too. If they moan, just let us know.

Join at the Double

Since June, Sessional GPs have been joining the NASGP at more than double the rate of previous years. With the move of our database from a static Access-based platform to a web-based MySQL serv... (sorry, just lost the will to live - Ed), the majority of the NASGP website is now password-protected so that only paying members can access the site's content. This extra income should then allow us to continue further improvements to the website as well as letting us increase our representation for Sessional GPs. So, a big thanks to you all for supporting the NASGP.

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Contact your LMC

Local Medical Committees are there to represent the interests of all GPs.

Make sure that you receive LMC newsletters, election details, etc, by sending your contact address to your LMC. Know what is happening locally and get your voice heard. LMCs are free to GPs in a levy paying practice (including freelance GPs). So get in touch with your LMC. What have you got to lose?

For your LMC, go to:
www.bma.org.uk
/ap.nsf/Content/Hubfindyourlmc



LMCs are ready to represent sessional GPs

LMCs now have the opportunity to be completely democratic and inclusive of all GPs. The new GMS contract has seen the move from a personal LMC levy system to a practice-based levy system (0.01% of practice income is paid towards the LMC levy). All GPs who work in a levy-paying practice are considered to be represented by that LMC. And more than likely, that means you!

This means that for the first time there is a level playing field for all GPs and both

the GPC and LMCs can finally begin to represent every GP.

LMCs should already have sent your contact details to the Electoral Reform Society so that you can receive ballot papers for regional LMC and GPC elections. If you didn't receive ballot papers for regional GPC elections this April then your LMC clearly hasn't got its head round this development, so our advice is for you to contact them as soon as possible so that you receive ballot papers for the election next April. Already, one regional election has to be re-run because it got this wrong and freelance GPs were not sent ballot papers. Now is the time to raise awareness about the issue and start working together to make LMCs and GPC more democratic and effective.

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NASGP News

We're constantly updating the website – for the latest, go to **www.nasgp.org.uk/news**. There's even a facility there to receive an email every time news is added.



Zoë Goodman has been running the West Yorkshire Non-Principals Group for the last several years and has already become a good friend of the NASGP. Here we find out a little more about her.



Can you tell us something about your home life?

I was born in Leeds and, having been away in East Anglia for nearly ten years, I returned to Leeds in 2002. I live with my partner, Cris, who's a writer, and we're currently involved in the (very expensive) process of planning our wedding for August 2006. Leeds has changed into a vibrant, cosmopolitan city and with its easy access to the Dales will always appeal to me far more than London ever could.

Describe your GP career so far?

I trained in Cambridge and then joined the first GP PRHO scheme in King's Lynn, Norfolk. I went on to the VTS there and moved to York (my first step back up North) after a year of VTS. I qualified in August 2003 and started as a salaried GP (and the only full-time permanent GP!) in a practice in Harehills, Leeds. I've watched our practice population change to include a large number of asylum seekers as well as the longer-standing ethnic groups in inner-city Leeds. In the course of one surgery, I can find myself using Language Line interpreters in Somali, Kurdish, Farsi, Arabic, Urdu, Mirpuri, Tigrinyan, Amheric, Arabic, French, Polish and Lithuanian. It is challenging work, with patients who can benefit greatly from the GP-as-advocate. It can include texting bus times to asylum seekers who cannot understand the timetables, as well as negotiating with secondary care providers about patients' rights to treatment. I've been a member of the NASGP for a while and it's made me realise the difficulty in organising groups of busy people into meetings, but also that there are lots of like-minded people out there: general practice does not have to be homogenous.

What floats your boat about general practice?

The huge variety of problems I encounter on a daily basis means there is never a dull moment. Only 1 in 50 patients presents with a sore throat. Our large South Asian population in Harehills has inevitably resulted in me developing an interest in diabetes. It's a cliché of general practice, but as time goes on it is the continuity of care and the relationship-building with patients and their families which I love. I had little idea of this as a GP registrar. I have an interest in complementary and alternative therapies (CAM) and I am a member of the GP Forum of the Prince of Wales Foundation for Integrated Health. There is much more to be done on evidence-collecting for CAM but if it works and does no harm, I'm curious! I'm undertaking some training in homoeopathy and acupuncture over the next 6 months and I would like to bring this into my inner-city practice. I am also in the middle of a life-coaching qualification with a US organisation called CoachU. Coaching has given me a few more strings to my consultation skills bow. One thing is clear from using CAM and coaching approaches, however: 10 minutes is not enough. I have set up a small coaching practice (www.lifespancoaching.com) which initially flourished when I was doing pro-bono (free!) coaching, but it needs much more nurturing before it becomes profit-making. I am now associated with what we've called an Integrated Obesity Management coaching programme called Attest, which two psychiatrist friends of mine have established. This uses coaching concepts in the management of obesity and it's going to be launched by the end of the year as a tool for PCTs.

Portfolio Lives

How do these passions influence the way you work as a GP?

I'm a great believer in consultation skills and the importance of having time to listen. I'd love to see 20 minute appointments as standard so that the MRCGP model of the consultation could become a more likely reality. I'm keen on becoming a GpWSI in General Practice – a rare bird indeed, perhaps.

What are your passions outside general practice?

I love running and I ran the New York Marathon with my fiancé in November 2004. I've got my eye on London 2006 now. I started with Race For Life in 2001 – 5 km seemed a very long way then. Running is a great stress-reliever – lots of fresh air and the relative peace and quiet after a day of patients definitely does the job. I love the Lakes and particularly the area around Buttermere and Ennerdale. I've recently been tempted by fell-running and I may try a race in the near future. I've also taken up surfing in the last couple of years. It's an incredibly difficult sport but with a great culture; a Saturday of surfing is the perfect antidote for a week of GP stress.

In what ways would you improve General Practice?

Apart from longer appointments, I think the isolation of GPs is what leads to many of the problems with stress and burnout. An official mentoring program may be very helpful in some form; a more obvious career progression another. I would like to end the belief among the dinosaurs of the medical profession that sessional GPs and part-time GPs are a lesser breed.

What are your career plans for the future?

I'm heading slowly but surely for partnership in some shape or form, but I keep dipping my fingers into other pies: coaching, writing, sports medicine, complementary and alternative medicine, teaching, travel medicine. If a partnership appeared in a teaching practice in the North East, I'd be there like a shot, surfboard under my arm.



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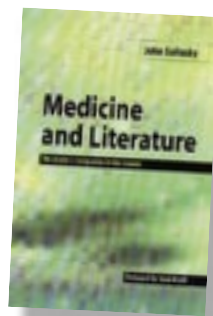
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How literature can bring us closer to our patients

In 1989, Iona Heath, an inner city GP in London, applied for study leave to spend three months reading novels. The Department of Postgraduate Education turned her down, but she took the three months off anyway and says it changed her life. The experiences of characters in fiction resonate with our own experiences, and those of our patients, and illuminate both.



There is fiction by doctors about doctors. AJ Cronin is not currently very fashionable, but there is more to him than Dr Findley. My favourite is probably more fact than fiction: Mikhail Bulgakov's 'The Country Doctor's Notebook'. While few 21st century British doctors will experience the loneliness of making life or death clinical decisions in a remote Russian village in the middle of winter, many of us may see our own early experiences as doctors distilled in his stories.

There are doctors in fiction by non-doctors. Poor Dr Lydgate in Middlemarch is always quoted – ahead of his time (using a stethoscope!) but destroyed by an injudicious marriage. GPs tempted by sexual indiscretion might remember him with fellow feeling. Doctors in literature suffer other problems. Frank in Damon Galgut's Booker-nominated 'The Good Doctor', or Eduardo Plarr in Graham Greene's (to my mind much better) 'The Honorary Consul', both remind us that it is not just overwork which causes burnout.

But what excited Iona Heath was not empathy with fictional colleagues. It was the human experience which novels portray.

The stresses and strains of infidelity – see 'Anna Karenina' in the nineteenth century or Sebastian Faulks' 'On Green Dolphin Street' in the twentieth. The psychological effects of guilt – 'Crime and Punishment' and 'Macbeth'. 'La Bete Humaine', Zola's superb study of temptation and corruption, and his even more chilling novella about guilt, 'Thérèse Raquin'. Mordecai Richler's 'Barney's Version' is an entertaining but telling study of the onset of Alzheimer's disease. William Horwood's 'The Scallagrig' gave me more insight into what it's like to have cerebral palsy than any number of textbooks. In 'The Way I saw Her', Rose Tremain gets into the mind of an adolescent boy, and there are times in consultations when I think of Lewis and how he copes with the loss of innocence. For those who can read Spanish, I would recommend Rosa Montero's 'El Corazón del Tártaro'. It is the best novel I have read this year, but not yet available in English. My Spanish is not that good but I was hooked by the suspense, the language, and the vivid picture of family dysfunction, the degradation of drug culture, and the painful path to redemption.

John Salinsky*, another North London GP, set out to tempt doctors into literature by outlining some of the pleasures awaiting those who dare to pick up the classics. He starts by analysing 'A Midsummer Night's Dream'. And you didn't think it was relevant to general practice? How about conflict between children and parents (Hermia and her father), team building (the yokel players), child custody (Titania and Oberon), the devastating effects of unrequited feelings (the lovers), the risks of eye drops when used by someone other than the patient for whom they were prescribed Well, that may be a lesson too far, but it is entertaining to think about what works of literature can teach us. And not just the classics. How about 'Bridget Jones's Diary'?

Films and even works of art can have the same power to illuminate our own experience. Would readers like to share their own favourites?

*Medicine and Literature John Salinsky 2002, Radcliffe Medical Press ISBN 1 85775 535 9