HELL IS OTHER PEOPLE'S VOMIT

I WOULDN'T SWAP WHAT I do for anything. But Monday mornings are still hell, and the first Monday morning of the new year is hell squared, so it was with a sinking feeling that I nosed my car into the Senior Partner's space the other day. (I'm not actually the Senior Partner; I just like to live life on the edge.)

Bleak House practice is located at one end of a small shopping centre which is itself on the outskirts of a sprawling estate of beige, shoebox houses. The view from my window is of a branch of Spar. Next to that is Bargain Booze, next to *that* is a 99p store and the rest of the row is made up of chippies, charity shops and a pharmacy.

In keeping with the locale, our building is a squat grey monstrosity. It's owned by the Primary Care Trust, which is, naturally, based in a gleaming new HQ which cost untold millions and looks like something out of *Battlestar Galactica*. By contrast, our rat hole positively reeks of decay. It was designed in the 1960s, built in the 1970s, remodelled for disabled access in the 1990s and has been scheduled for demolition and replacement ever since. When – or perhaps if, given the state of the economy – the new one is eventually built, it would be nice if it was more health centre and less concrete cancer.

I paused before opening the reception door. On the bricks above the portico, someone had scrawled the words '*Fuck you knobhead*'. I'm not sure why, but this piece of graffito seemed to me to be the perfect mission statement for us. It certainly beats 'Working in the community for your good health'. I resolved to suggest we add it to our headed notepaper at the next Partners' Meeting.

I pushed open the door and walked in.

It was only just 8am. The place was quiet, but the atmosphere was pregnant with anticipation – like a Caribbean island awaiting a

hurricane, or a battlefield before the first shots are fired. Within half an hour, chaos would reign: standing room only, phones ringing off the hook, a dozen overweight mums pushing buggies back and forward and a gaggle of confused and apprehensive elderly people huddling in a corner as snotty-nosed toddlers hurtle around, shrieking. But for now, there was only a scattering of early birds. A teenaged girl and her worried mother sat together glumly, the girl flicking desultorily through a dog-eared copy of *Heat*. A middle-aged male patient was jabbing his finger at a couple of nervous receptionists and snarling something about antibiotics. They used to be a bit less nervous in the days when they sat behind a thick plate glass screen, but that was removed a while ago after the PCT deemed it too 'threatening'. Lurking somewhere in the background, in case it got a bit tasty, was Mrs Peggotty, the reception manager. She hails from County Sligo, has a squint and forearms like an all-in wrestler, and she takes no nonsense from anyone.

There was only one other punter, an elderly man who was hovering near the desk, and he grabbed me on the sleeve as I passed.

'Here,' he said. 'Can you help me with this? Only I can't understand the bleeding thing.'

He was standing by the booking-in computer.

'Well,' I said. 'Where it says, *Enter date of birth*, you need to enter your date of birth.'

'Yerwhatter?' he said.

'What's your date of birth?' I said.

'July 11th, 1937. Only, it was the day George Gershwin died and…'

'Yes, yes,' I said. 'You see, you type that in here like *this*… and we find that you are Mr Alf Tupman of 15 Back Street. Do you see? And you have an appointment to see me at 8.40am. So it tells you to go and wait outside Room 3, which is my room. Is that OK?'

I hurried on before Mr Tupman could tell me, and the assembled throng, that the pile cream I had recently prescribed him was no bloody good.

DNA TESTS

MY FIRST PATIENT of the day was a 'DNA' – meaning she Did Not Attend.

You'd be surprised how many of these GPs get. The Royal College of General Practitioners says 10 million appointments a year end in a no-show. When you factor in that each appointment has a 10-minute slot set aside for it, you can see that literally years of quality doctoring time is being frittered away.

Officially, we think DNAs are a Very Bad Thing. From time to time, notices will appear in waiting rooms informing patients that 30 people failed to keep their appointments last Tuesday week, and that five hours of their doctor's precious time was wasted as a result. Some politicians have floated the idea of allowing us to charge non-attenders, while the more hard-hearted and money-grabbing members of my profession talk about charging *everyone* for appointments, on the basis that if they've paid for it they'll use it. (Opponents say that such charges might discourage patients from seeing the doctor. Er, yes. That's the whole idea.)

I suppose you do have to wonder exactly what kind of person might book an appointment to see a doctor, thus preventing anyone else from booking the same slot, and then not bother to show up, but the fact is – entirely *un*officially – I love DNAs.

As I sat there at my desk, contemplating a mound of unopened and almost certainly pointless post from the previous Friday, Sami Patel popped his head round the door.

Sami, the most junior of our four partners, is a thrusting young lad from Manchester whose dad runs a big practice up there. He drives a silver Porsche Boxter, his girlfriend looks like Miss India's prettier sister and he is a very good doctor. I ought to hate him, but somehow I just can't.

'I thought you were off today,' I said.

'I am,' he said. 'I've just nipped in to get my QOF points in order.'

Sami is mad about QOF – Quality and Outcomes Framework – points, of which more later.

'Anyway,' he went on, 'you'll love this, Copperfield. Bloody Gordon in reception obviously forgot I was off, because he's just put a call through to me from a bloke who was due in for his well-person check on Friday when he twisted his ankle on the way. So he limps off to A&E, where they fob him off with a script for some anti-inflammatories, which obviously he's got to pay for, and he rings up this morning to apologise for not coming in. So I say to him, "You had to pay for your ibuprofen, you had to fork out six quid to park there and now the the Health Select Committee is talking about fining you for missing his GP appointment. Your ankle may not be broke, Mr Westlock, but you soon will be!" Get it? "Your ankle may not be broke…"'

'Very good, Sami,' I said. 'Stick the kettle on.'

Six quid to park at St George's, I thought. *Not to mention the fiver to pay some young scally to watch your car.* No wonder so many patients abuse the ambulance service: it's door-to-door, with no meter to feed. Gordon Brown promised to abolish car park charges at hospitals, but typically failed to suggest a realistic way of making up the resultant funding shortfall.

With six minutes to go before my next patient was due, I ambled down the corridor to the common room.

Sami was pouring boiling water into the cafetière.

‘Hmmm,’ I said, sniffing the air. ‘Hand-roasted Guatemalan, if I’m not mistaken?’

He stopped stirring and stared at me. ‘How did you…?’

‘From Santa Ana la Huerta,’ I said. ‘Interlayered flavours, nuances of berries, honey and dark chocolate. A strong, yet elegant, bean.’

He followed my eyes to the packet of Union Hand Roasted Guatemala Coffee (100% Arabica, £2.79 from Ocado, tastes like the contents of a specimen jar) lying next to the kettle, and groaned.

He started pouring the coffee.

‘What I said about DNAs,’ he said. ‘To be fair, the government has a point. You’ve had one first thing this morning, there was my twisted ankle bloke on Friday, we had a dozen others that I can think of last week. We’re averaging 60 a month, in this practice alone. It’s tax-payers’ money, is this. Personally, I agree – DNAs ought to be fined.’

‘You must be mad,’ I said. ‘If we were to start fining them for not turning up, what do you think would happen?’

‘Well,’ he said, regarding me as though I were a simpleton. ‘A few more of the buggers might turn up.’

‘Precisely,’ I said. ‘Can you imagine what it would be like if everyone who booked an appointment at the surgery came in? When would we find the time to catch up on paperwork, check blood test results, write referrals? Not to mention coffee and Sudoku. The NHS would collapse overnight. Fine them? We should reward them.’

‘Hmmm,’ said Sami. ‘I hadn’t thought of it like that.’

‘That makes two of you,’ I said. ‘You and the Secretary of State for Health.’

He meandered out, and I stood pondering awhile, safe in the knowledge that my own DNA afforded me a few minutes of precious peace, with nothing to concern me but a Hob Nob. If people don’t

want to turn up, that's their shout. I have far better things to do than checking Mr Harris's ankle jerks, trying to look at the tympanic membranes of malevolent three-year-olds and listening to Mrs Mowcher's description of her funny turns, the ones that only happen during *Coronation Street* on a Wednesday, for the 13th time to make sure I haven't missed an obvious diagnostic clue the first dozen times around. Give me a surgery of 17 booked appointments with 15 DNAs, and that's as near to heaven as I get.

TRUE COST OF DRUGS

JEFF BRICK was in to see me later on.

He never bloody listens to a word I say, which often leads me to wonder why he bothers consulting me. Mainly, I suspect, it's for his inhaler. After a lifetime working as an industrial welder on top of a 40-a-day Benson and Hedges habit, Jeff suffers, unsurprisingly, from dyspnoea (shortness of breath).

Periodically he comes in for a check-up and a new puffer, and I carefully explain the importance of using it properly, and taking exercise, and quitting the fags, and he nods blankly as the words enter his left ear and exit the right without troubling the scorers within.

Anyway, I printed off his prescription, signed it and handed it to him, and waited for him to get up and go. Instead, he sat there looking at it, his brow furrowed. Eventually, he said: 'What's this price thing by where it says about me inhaler, then?'

I took the script back. Sure enough, it was there in black and white. I read it out: 'Seretide 250 Evohaler. Use twice daily as directed. Supply 1 (one) inhaler. £59.48.'

'Hmmm,' I said. 'Well, for some reason I can't fathom, the computer has printed off the actual cost of the inhaler. It shouldn't

do, and as I say I'm not sure why it has, but there it is. That's what they cost – nearly sixty quid.'

'You're taking the piss, mate,' he said. 'I ain't payin' that.'

'You're not,' I said. 'It's just the usual seven quid-odd to you. The £59.48 is what it costs the NHS.'

'You're 'avin' a larf!'

'Er, no.'

'You're pullin' my plonker!'

'Look… no, I'm not. That really *is* what the NHS spends on the inhalers which you use like air fresheners because you can't be bothered to read the instructions.'

'Stone me.'

I'd quite like to, I thought, as he shambled out, muttering to himself.

I called through to reception. 'For some reason, my PC is printing scripts off with the prices,' I said.

'Yes,' said Mrs Peggotty, the reception manager. 'I've just had Dr Emma call me to say the same thing. I'm ringing the IT people now doctor, don't you worry.'

The NHS IT infrastructure which helps me 'Deal With Today's Problems Today!'®, runs on vastly outdated software, so perhaps I ought to be thankful that it only crashes and burns every other fortnight. Still, it won't surprise any reader with half an interest in government computer systems to learn that this particular problem persisted for a further five days.

I say 'problem', but it was actually a blessing. In fact, it was brilliant and it ought to be a permanent feature of all prescriptions and medicine labels: if patients knew the real cost of their medication, maybe they'd be less cavalier about forgetting to take it, losing it or flushing it down the loo. Those who pay prescription charges and bitch about forking out £7.20 per item – pretty cheap for an inhaler costing nearly 60 quid

– might change their tune, as would those who buy an annual ticket for £104 and act as though they're taking out a second mortgage, rather than handing over the price of a second-hand Nintendo Wii.

Conversations along similar lines peppered the next few days. Psoriasis sufferers couldn't believe a month's supply of scalp ointment ran to £108, a man on anticonvulsants had a fit – well, nearly – when he realised how much he was denting the NHS budget, and an old lady taking a cholesterol-lowering drug actually apologised when she found out that she was costing the NHS £80 every time she handed in her repeat prescription on the first of the month. And *she* was one of the ones where the money seemed well spent (I'm afraid that making value judgments about my patients goes with the territory).

So by the time Yvonne Claypole rang I was well up for it.

'Hello doc, listen, do me a favour, yeah?' she said. 'Only, I went over to Bristol to see my sister's family at the weekend, yeah? I had the prescription you gave me last week for my migraines made up while I was there, yeah, and, d'you know what, I've only gone and left all me tablets down there. Leave another prescription with Mrs Peggotty in reception, there's a love, and I'll pick it up in the morning.'

'Can you just hang on a mo?' I said. 'I just want to check something.'

I laid the receiver down, printed a script off and looked at it.

Imigran Radis tablets 100mg. Take one at onset of migraine. Supply 1 (one) pack of 12 (twelve) tablets. £85.80.

Eighty. Five. Quid. On headache tablets for a woman who is so bothered about her problem that she has forgotten where she put the last lot of pills.

I got on to Google. Then I picked the phone back up.

'Listen, Yvonne,' I said. 'Can you get yourself to the coach station in town by 8pm? There's a bus to Bristol leaving at half past. It's

£18.50 return. And do give my best wishes to your sister and her family.'

DRUG BUDGETS

GIVEN THE ABOVE, I suppose I ought to explain drug budgets. We don't have one, as such – in the sense that you can't run out of money, come November. What we do have is an Indicative Prescribing Budget (IPB) and a Prescribing Incentives Scheme (PIS).

The IPB was introduced a while back and is an amount of money allocated to your practice on a computer at the PCT. It's based on the number of patients on your list, some very basic and unsophisticated demographics (a GP in Eastbourne might get a little more money to reflect the fact that all his punters are OAPs), and also on historical prescribing patterns. (In the months before it came in, I'm told that some unscrupulous doctors were wildly prescribing everything they could to anyone they found near the surgery, on the basis that this would push their budget up. A nice idea – wish I'd thought of it.)

The incentives scheme is a list of criteria; the more of these boxes you tick, the more money you earn for your practice. Among them are things like not prescribing expensive antibiotics, or not prescribing too many antibiotics, or keeping within your indicative budget, or not going more than 5% above it. Another revolves around the percentage of generic drugs you prescribe, as opposed to branded ones. When a drug is first released, it is patented. Once the patent runs out, anyone can manufacture it – these 'generics' are cheaper than the original branded drug but generally have exactly the same properties.

As I say, you can't spend your 'budget' and run out of money, but if you bust it you'll end up getting a visit from a Prescribing

Advisor from the PCT asking why your prescribing costs were so high and refusing to pay your PIS money. (Unless, of course, you can justify your prescribing. Some years are busier than others.) None of this involves the really expensive blockbuster treatments, like the breast cancer superdrug Herceptin – if someone on your list needs something of this order, you write to the PCT and they will deal with it as an exceptional case.

NHS IT EXPERT — MORON OR OXYMORON? DISCUSS

WITHIN A WEEK or so, the PC doctors had finally fixed the computers and we returned to state normal, where no-one knows what his pills cost.

Next week, something else will go wrong, of course.

I can't for the life of me understand why those in authority place so much faith in computers. This question occurred to me one morning as I attempted, with gritted teeth, to type in a prescription for Mr Snagsby, one of our frequent fliers.

The latest 'helpful update' to the IT systems in our surgery is a program which interrupts me as I'm writing prescriptions for Drug X to inform me that a different drug, Drug Y, would work out 94p per month cheaper.

Because it is a computer system commissioned, designed and implemented by imbeciles, it does not take into account the fact that I know full well that Drug Y is cheaper, but that I have already tried that drug on the patient without success, or have discovered that the patient is dangerously allergic to it, or that I've thought about it but have considered it unsuitable in my professional, that is to say medical, opinion.

Unless I push three different buttons to confirm my original choice, the patient gets switched by a process called ValuScrip to the cheaper version, which is annoying enough.

Worse, though, the PCT are monitoring how many of ValuScrip's recommendations I act on (almost none, as it happens) and they reserve the right to penalise my drug budget by withholding PIS payments if I don't accept a certain proportion of them.

Musing on the difference between a Secretary of State for Health and a GP's computer – chiefly, that you ought only need to punch the information into a Secretary of State once – I eventually achieved the desired result and sent Mr Snagsby on his way with a chit for drugs that may be slightly more expensive than the bean counters would ideally like, but will at least work and have the added benefit of being unlikely to kill him via anaphylactic shock.

It's all of a piece with the 'Connecting for Health' NHS computer system, the black hole that will have swallowed up around £7 billion of our hard-earned tax by the end of 2010. Doctors have been banging on for years about the inadequacies of this programme, with its twilight language of 'Clinical Dashboards Toolkits', 'NHS Interoperability Toolkits' and 'Enterprise-wide Arrangements'.

One aspect of the software is supposed to speed up the process of booking an appointment for a patient to see a consultant. This particular facility is so awful that most GPs refuse to use it, even though patients referred with an old-fashioned letter are theoretically forced to wait longer for their first appointment at the hospital.

The white-coat-and-bow-tie merchants are just as cross about this as GPs, ploughing through clinics full of bunions while little old ladies with painfully crunchy hips are bounced back down the waiting list because their GP sent them along with a handwritten note.

Then there is the issue of security. I've had many patients ask dubiously whether their health records are safe once they are loaded

on to the centralised 'NHS spine'. My response: I very much doubt it. The IT nerds insist that electronic records will be more secure than paper-based notes. I look at the almost weekly incidents of thousands of computerised records being left in pubs, emailed to the wrong place or outsourced to India, and then point out that my filing cabinets are locked and I know who has the keys.

The geeks are trying to persuade us that their new systems will improve communication between GPs and hospitals. This is rubbish. My local pathology laboratory installed the latest hideously expensive software a while ago, and the system crashed before the engineer had left the building. For several days, thousands of results had to be faxed or couriered to surgeries while some intensive head-scratching, chocolate-digestive munching and rebooting went on at the lab. When the computer lurched back into action, it sent *seven* copies of *every* test result in its memory into GPs' inboxes, including tests that had been requested by, and should have been reported to, hospital doctors. Then everything crashed again.

The letter of apology that followed was addressed to 67 local GP practices. That's 200 doctors, give or take, who had been repeatedly switching their PCs on and off again after phoning Tech Support.

Still, the technophiles won't give up. Another pilot project allowed patients to see their records and download their test results via the internet. Brilliant – if the scheme is ever rolled out across the country, my patients will be able to discover that they have an inoperable brain tumour from the comfort of their own home. At least that will save me the trouble of my breaking it gently to them.

Why wait? Show up at the surgery with some ID and a few quid and the Data Protection Act ensures that you'll get a printout of your entire computer record: every diagnosis, every prescription, every blood-pressure reading, to do with as you please.

I wonder what you'll make of this:

'TATT 2/52 FH ↓T4 O/E NAD TFT+FBC 2CMA'

Try, 'Tired all The Time, for two weeks, has a Family History of Hypothyroidism, On Examination Nothing Abnormal was Detected, lab rats asked to do some Thyroid Function Tests and a Full Blood Count simply To Cover My Arse.'

MEET REBECCA BAGNET (OR HER DAD, ANYWAY)

AFTER A NOURISHING breakfast of paracetamol on toast and a slug of pholcodine linctus BP, I dragged myself into the surgery today.

You might think that doctors would be good at judging when we're fit for work, considering that a large part of our working day is spent assessing our patients' ability to do jobs we know next to nothing about. Ironically, it isn't so. It's a macho thing: 'proper' doctors don't take sick leave.

First out of the morning's traps was Matthew Bagnet, who had blagged my 8am slot for a prescription review. As he came in he was treated to an exhibition of world class expectoration as I tried to get a particularly stubborn gobbet of phlegm to shift from the back of my throat.

'Blimey, you ought to see a doctor yourself,' he said, as he plonked himself down in the patient's chair and rolled his sleeve up for the ritual blood pressure check.

Wordlessly, I reached into my desk drawer and pulled out a sheet of A4 paper bearing the legend 'YOU SHOULD SEE A DOCTOR'. I crossed out the number 23 and wrote in '24'.

'Ah,' he said. 'You've heard that one before, then.'

It was when we wrapped up his BP check and 12,000 mile service that he hit me with his, 'While I'm here, doc.'

But it wasn't about himself, it was about his daughter, Rebecca. I've seen Rebecca grow up from shy toddler, through highly-strung schoolgirl and into troublesome adolescent.

'It's her diabetes,' he said. 'She's just not taking it seriously.'

He wasn't telling me anything I didn't already know. I'd had a succession of letters from the local Diabetic Day Care Centre, ranging from the straightforward, 'We were sorry that Rebecca couldn't make it in for her assessment today,' to the more recent, 'We really wonder whether it's worth sending this girl any further appointments,' after she failed to attend for the fifth or sixth time.

Along with these there were copies of attendance alerts from A&E departments round and about, all following the same pattern: 'Known insulin-dependant diabetic, low blood sugar, treated and streeted. GP to follow up.'

'OK, Matthew,' I said. 'No more Mr Nice Guy.'

I pulled Rebecca's repeat prescription chart up on the screen, selected 'All Items' and hit the delete button. 'I'm not putting my name to any more insulin scripts until I see some blood numbers, a body mass index and a BP reading on Becca's record. Get her over here before her current supply runs out.'

IMAGINEERING SOLUTIONS FOR SHIFTING PARADIGMS

SAMI AND I HAD a meeting with the PCT suits later.

It all started about a year previously, with a squeal and an expletive from my medical secretary Martha Bardell, both of which

were audible from the common room. Such displays of exasperation are unusual from the highly professional and controlled super-sec, so I immediately went to investigate.

I found her hunched over in her chair, slowly banging her head against the desk and moaning.

'Everything alright?' I said, casually.

She looked up and almost growled. 'I don't believe it!' she said. 'It's *another* bloody form!'

More swearing. Blimey! This was serious.

She handed it over. It was, indeed, *another* bloody form. This time, for microscopic haematuria – invisible amounts of blood in your urine. The form – which needed completion by the GP to get the patient referred to a urologist – required around 25 separate pieces of information. Name of patient, obviously. Any abnormal findings on examination, also obviously. But, rather less obviously, questions like, 'Any recent travel?' – perhaps because (and I confess I'm guessing here) obscure tropical diseases can sometimes cause microscopic haematuria.

Anyway. Big deal, you might think. It's just a form. Bite the bullet, fill it in, move on. Fair enough. But then, there's a form for chest pain. And one for indigestion. And another for rectal bleeding. And yet another for headache. And for heavy periods, and infertility, and breathlessness, and memory loss… In fact, no matter what your symptom is, there's a form for it (admittedly, I haven't yet tested this out for the most obscure symptom I can think of, pilimiction – the passage of hairs in your urinary stream – but I have a feeling I wouldn't be disappointed).

There are lots of symptoms, so that's lots of forms. And they need keeping track of, filing and updating, and, of course, the hospital keeps producing new ones and updates on old ones every five minutes. This upsets Martha.

Each form is completely different, each needs tracking down and each needs laborious completion with information that either seems irrelevant or which the hospital doctor is going to get from the patient anyway. And this upsets all of us, because it's a pointless waste of time, effort and, in these recessionary times, money.

Over the following few days, phrases like 'bureaucratic nightmare' and 'unbelievable levels of bullshit' were bandied about, increasingly loudly and vehemently, until, at the next practice meeting, we decided that enough was enough. We would make a stand and stop using those sodding forms. Instead, we reverted to what we'd always done: writing a sensible, courteous referral letter, providing all the information relevant to the particular case but none of the nonsensical frippery.

Brilliant.

Except that, on day three of our brave, form-free world, the first referral bounced back. The next day, a couple were returned. The next, a handful. And then it became apparent that all of our referrals were boomeranging back to us.

Why? To quote the message sent to a molar-grinding Martha, 'These referrals have been refused because your doctors have not used the correct forms.'

This was sorted out by a few choice words directed to some jobsworth on the end of the phone.

'We have a contractual obligation to refer patients to hospital as appropriate,' our Senior Partner told the jobsworth, 'but we are under no obligation whatsoever to use any particular form, any more than we are to fill it in in illuminated script. Which means that, should any patient suffer harm because of your refusal of our referral, medicolegal liability will be held by you.'

This solved the problem. But we'd created such a stir with our policy of non co-operation that the PCT suits weren't happy, which

is why Sami and I found ourselves sitting opposite a couple of them this morning.

The meeting went well. Sami explained our position from the outset. He's good at this type of thing: he hates management jargon, but he has a weird talent for it, too.

'The thing is,' he said, 'we don't want our stance to get in the way of a seamless patient journey.'

The suits looked impressed.

'Nor do we want it to reflect badly on our aspiration to Total Quality Management. We'd hate to see a dip in the dials on our Clinical Dashboard.'

The suits glanced approvingly at each other.

'So we've had an idea shower. And, going forward – bear with me – we've come up with a paradigm shift. We'd like to give you the heads up, run it up the flagpole *et cetera*.'

He pulled a piece of paper from his pocket. The suits were obviously intrigued, leaning forward slightly, waiting expectantly for Sami to unveil our masterpiece.

'Clearly,' he continued, 'the status quo isn't a strategic fit for World Class Referring. So we've imagineered a solution.'

Bugger me, he's good. He unfolded the paper.

'We're calling it a "Universal Referral Form", or URF. It's a one-size-fits-all solution. We've cascaded it to local practices and they've all confirmed they think the idea is…'

For the first time, he faltered, searching for the right buzzword. I took this as my cue to chip in.

'They think it's empowering,' I said.

'Exactly!' said Sami. 'They think it's empowering.'

The suits could barely contain their excitement.

'We think we can work synergistically with you to facilitate this across all practices,' said Sami, recovering his poise and handing

over our meisterwork. 'It's kind of a win-win-win. You, us and the patients.'

The suits looked blank. As did the piece of paper they were holding.

'This is a piece of headed notepaper?' said Suit one, slowly.

'With nothing on it?' said Suit two.

'That's right,' beamed Sami. 'On which we write a referral letter. A Universal Referral Form, like I said. We'd like to enter it for the Strategic Health Authority's annual awards. The "Innovation" section. If you could just sign our entry here?'

'Are you sure you've used the right entry form, Sami?' I said.

CHARLIE DARNAY AND ME

TWO MONTHS AGO, Charlie Darnay, a bright bloke in his mid 20s who was studying hard for a challenging IT qualification, came to see me. He complained of a variety of things – *inter alia*, that he couldn't sleep, he had aches and pains in his joints, a persistent sore throat, problems concentrating, short-term memory lapses and occasional dizziness and nausea. If he did any exercise, such as the weekly game of squash that he used to enjoy, things got worse rather than better. His performance at college was suffering and he was worried sick that he'd fail his next set of exams.

I ran some blood tests to check for various possibilities, such as anaemia, diabetes and thyroid trouble, and they all came up blank.

I had him in again to decide where to go next.

'The results were all inconclusive,' I said. 'We can rule out anything really serious, I think, but…'

'Could it be ME, doctor?' he said. 'My girlfriend was reading about it in one of her magazines and it sounds like what I've got.'

'Hmmm,' I said. 'Well, your symptoms certainly fit the diagnostic criteria.'

ME – short for myalgic encephalomyelitis, and also known as chronic fatigue syndrome (CFS) – is a controversial condition, with attitudes ranging from those who doubt its very existence to those for whom it seems to be their *raison d'être*. Things get surprisingly heated in both camps, especially considering that we're dealing with people who say they're suffering from very low levels of energy. Whatever. There's a bloke in the Rheumatology Department at the local hospital – Dr Snitchey – for whom it's a special interest. Not long back, I attended a lecture he gave about the issue and he seemed a good sort; the obvious thing to do was to get Charlie and Dr Snitchey together.

You may have heard of the new NHS system called Choose and Book which – in theory – entitles patients to choose when and where they go for treatment. The thing is, it's a pretty complicated and exhausting process, and since Charlie was *already* exhausted he asked me to sort it out for him.

This is where it gets irritating.

'So, can you arrange for me to see this Dr Snitchey, then?' said Charlie.

'I'd like to send you to see him,' I said, 'but I… er… can't.'

'You can't?' said Charlie. 'But I thought you said he was an expert in the field?'

'He is,' I said. 'Not that long ago – I mean, only five or ten years back – it would all have been very straightforward. I would have written a letter directly to Dr Snitchey via his secretary, and you would have toddled off to see him in his clinic. Job done. Unfortunately, we're not allowed to book like this any more.'

'You're not?'

'No.'

'So what do you do?'

'These days, I have to write a general referral letter to the hospital. All I can really do is address it to Dr Snitchey, with strict instructions that only he or his secretary opens it, making it plain that you need to see him, and hope for the best.'

'Well, surely if it's addressed to him he'll open it and they'll just book me in with him?' said Charlie.

'I wish it were that simple,' I said, 'but, in my experience, what will probably happen is that the letter will find its way to the Referral Management Centre.'

'What's that?'

'It's a room somewhere with a lot of computer screens and telephones where they collect all the hospital referrals sent up by GPs and decide who the patients get to see.'

'Right,' said Charlie, looking puzzled. 'So surely *they'll* send me on to Dr Snitchey then?'

'Hmmm,' I said. 'You'd like to think so, wouldn't you? Unfortunately, they don't take much notice of what we write in our letters. They tend to make up their own minds as to what treatment you need.'

'But at least they're doctors, right? The people in this Referral Management Centre?'

'Er, no. They're just bodies sat in front of computers, ticking boxes and pushing paper. The chances are they will see that the letter has been addressed to a consultant in the rheumatology department, so you'll end up being sent to a consultant in that department, but not necessarily Dr Snitchey.'

Which is exactly what happened.

Charlie entered the twilight world of the Referral Management Centre, they ignored my request and arranged instead for him to see Dr Snitchey's colleague, Dr Craggs. Craggs is perfectly capable when it comes to arthritis and systemic lupus erythematosus,

but has no interest or expertise whatsoever in chronic fatigue syndrome.

This morning I received notice from the hospital telling me that Dr Craggs had examined Charlie and that he felt, on reflection, that he would have been better off seeing his recently-appointed colleague Dr Snitchey who works just down the corridor. Snitchey has special expertise in the management of these cases, don'tcha know?

Yes, I do – but a fat lot of good it did me or my patient.