JOHN FRY TRUST FELLOWSHIP
1995

The Mystery of General Practice

Iona Heath

THE NUFFIELD PROVINCIAL HOSPITALS TRUST

THE JOHN FRY TRUST FELLOWSHIP

When he retired in 1991, after 45 years as a general practitioner, Dr John Fry established a Trust the main aim of which was to further the development of primary health care.

Through this Trust a Fellowship was established to be awarded annually to a distinguished individual from any discipline. Each holder of the Fellowship would be invited to prepare a monograph which it was hoped would contribute significantly to the progress of primary care. The monograph would be introduced by a public lecture to be delivered at a recognised teaching centre in the United Kingdom.

IONA HEATH

Iona Heath graduated from Cambridge University in 1974, having done her clinical studies at the London Hospital Medical College. She completed little over a year of junior hospital posts, and entered general practice just before three year vocational training became mandatory. In September 1975, she joined Hugh Faulkner's innovative Caversham Group Practice as a trainee, and never left. She became a partner in 1977. The practice is based at Kentish Town Health Centre in north London.

She has been a GP trainer since 1983 and a member of Camden and Islington Local Medical Committee since 1989. In 1989, she stood in the national ballot for the Council of the Royal College of General Practitioners to protest about the threat to suspend GP training in the North East Thames Region. She has served as a member of College Council since then. She is now Chairman of the College's Inner City Task Force and Editor of the International Newsletter. She represents the Royal College of General Practitioners on the Council of the British Geriatric Society.

Since 1993, she has been an editorial adviser for the British Medical Journal and a member of the editorial board for the Oxford University Press General Practice Series. She has two neglected children and a long-suffering husband.

Acknowledgements

I owe an enormous debt to the many patients, friends and colleagues who have taught me about general practice over the years. In the preparation of this monograph, I am grateful to Godfrey Fowler for his belief in me, to Michael Ashley-Miller for his consistent support and encouragement, and to David Morrell and Carl Edvard Rudebeck for their reassurance. In particular, I wish to thank Stephen Amiel and Duncan Keeley for their painstaking criticisms of earlier drafts. Typically, I have resisted some of their advice and the remaining faults are my own. Most of all, I thank David Heath for tirelessly reading and commenting on every draft, for his belief that I had something to say and for doing much more than his share of the ironing.

Contents

1
Introduction

1
Introduction

Sadly, I did not have the opportunity to know John Fry well, but I did have the privilege to serve with him on the Council of the Royal College of General Practitioners during the last year of his thirty year tenure. John Fry made a unique contribution to general practice research through the careful recording of his daily work in Beckenham. I have no credentials in research, but I do aspire to share with John Fry a love of ordinary general practice and a firm belief in its power to improve the health of individuals and populations[1].

My title came originally from my delight in discovering that a mystery was an early collective noun for doctors. An archaic meaning of a 'mystery' was 'a trade, profession or calling', and as such a mystery was used to describe a faculty of our precursors, the barber-surgeons, in the late middle ages.

Within its more usual meaning[2], mystery is the subject of this monograph. The mysterious secrets of the trade or art of general practice seem to be poorly understood outside our discipline and, in the face of the current avalanche of change, there is an increasingly urgent need for us to explain ourselves. Carl Edvard Rudebeck, writing about the struggle to establish and develop general practice in Sweden[3], argues:

> *'General practice was pushed into defining itself at its own margins, leaving its very centre, its specific priorities, unfathomed by both critics and spokesmen.'*

Here in the UK, we have the same problem. The pace of change has been rapid and seems to be accelerating. We are continually having to adapt our practice and our attitudes, and in so doing we tend to lose sight of those parts of our work which should not change because they deal with enduring

aspects of the human experience of illness and disease[4]. Unless we are able to make our specific contribution explicit, we will not be valued and we may be lost.

We might ask why the key transactions of general practice are mysterious. I suspect that it is because they have developed out of an inarticulate mix of intuition and experience, and that we only slowly begin to understand them ourselves when we embark in practice as young doctors. We research, teach and learn about the dynamics of the consultation but, somehow, often continue to assume, rather than explain, the nature of the fundamental transactions.

This monograph begins with some of the components of the current malaise in general practice, and, after a brief discussion of the nature of medicine, goes on to attempt to lay open the secrets, mystery and particular contribution of general practice. In so doing, I hope to demonstrate the crucial value of general practice, to define the prerequisites for, and the threats to, its survival and to argue the case for its active perpetuation through education and research.

Notes and references

1 Fry J, Horder J. *Primary health care in an international context.* London: Nuffield Provincial Hospitals Trust, 1994.

2 Definitions of mystery given in the Oxford English Dictionary include:
A hidden or secret thing; a matter unexplained or unexplicable'
'The behaviour or attitude of mind of one who makes a secret of things usually for the purpose of exercising undue power or influence'
'An action or practice about which there is or is supposed to be a 'secret' or highly technical operation in a trade or art'

3 Rudebeck CE. General practice and the dialogue of clinical practice: on symptoms, symptom presentations and bodily empathy. *Scand J Prim Health Care* Suppl 1/1992.

4 Willis J. *The paradox of progress.* Oxford: Radcliffe Medical Press, 1995.

2
The Current Crisis

2
The Current Crisis

It is now five years since the Government imposed changes on the National Health Service, introducing, almost simultaneously, the purchaser-provider split and the New Contract for General Practice. These changes have precipitated a crisis in the morale of general practitioners and a fall in the number of applications to join general practice training schemes. More recently, the Department of Health has called for the development of a primary care led NHS[1]. General practitioners are being asked to extend their role in many different directions and there is a feeling that politicians and health service planners are seeking to place general practice at the centre of the NHS without properly understanding the essential transactions of its discipline[2]. Throughout the profession, there has been a perceived need to rediscover core values[3] and this has been particularly marked in general practice[4]. This need must derive from a sense of threat, a feeling that in adapting to the avalanche of change we are in danger of losing something precious, something that once lost will be difficult, if not impossible, to regain. That something seems to be concerned with the intimate interaction between the individual patient and the generalist doctor and I will discuss this in detail later. First it is necessary to address those developments which are both undermining and distracting attention from the essential nature of general practice.

Market values and the destruction of vocation

By introducing market values into the transactions of health care and by turning patients into

consumers, while at the same time putting strict limits on the resources available, the Government has trapped health workers in the credibility gap between rhetoric and reality. Charters offer a superficial vision of quality which has everything to do with being a consumer but very little to do with the needs, priorities and responsibilities of being a patient. Most patients understand John Howie's definition[5]:

> *'Effectiveness is the ability to justify extra time spent on one patient in terms of the cost imposed on all succeeding patients.'*

Patients recognise that moments of crisis, such as collapse, bereavement or the communication of a serious diagnosis, require extra time and most are prepared to meet the cost in the belief that they will benefit at their own moment of crisis. This is not the logic of the consumer or the market[6]. Markets thrive on individual gratification which is devoid of a social context. They are linked to a form of politics which seeks to minimise not only taxation but also the obligation to invest in social justice.

For us as health workers, every component of health care appears now to have its price – we are exhorted to consider the financial implications of our every action. Not surprisingly this has led us in our turn to consider the financial value attributed to our work and this has resulted in an attrition of vocation. The 'Out of Hours' story tells much of this. Patients are turned into consumers and given rising expectations of what they have a right to expect, doctors are turned into purveyors of a commodity rather than members of a vocational profession providing a public service[7]. Patients begin to ask for medical attention at night for worries which could wait until the following day. Doctors begin to look at precisely what they are paid for offering a 24 hour service 365 days of the year and they find that it is very little for the discomfort of having to get

out of a warm bed after a long day's work and with the prospect of another one only a few hours away. By failing to value the notion of professional vocation, our society is allowing it to wither away. This is something precious which seems already lost; there may be much more to lose. Thatcherism's most dangerous legacy may prove to be this erosion of professional and vocational motivation and its replacement by the single-minded pursuit of financial and material reward. Such self-seeking has become the acceptable norm and the great challenge for the future is to rediscover a sense of vocation and of society.

The conflict between advocacy and distributive justice

General practitioners are increasingly aware of the conflict between their role as the individual patient's advocate on the one hand, and, on the other, their increasing role in decisions about the distribution of scarce resources within a population. The trust of the patient depends on their belief that their general practitioner understands and empathises with the needs they express and this impels and empowers the general practitioner to act as the patient's advocate. This advocacy role inevitably conflicts with involvement in decisions about the distribution of limited resources. It is not possible to strive simultaneously for the individual and the collective good. The two are based on quite distinct ethical principles and there will always be problems when collective principles are applied to the care of individuals[8]. The problem is acknowledged by the Chief Medical Officer[9]:

> *'It may be necessary to separate decision making at the bedside from resource allocation at a higher level.'*

And yet the pressure on general practitioners to become

fundholders is intense. The conflict of interest must be understood for the profound dilemma that it is and not dismissed as a shirking of responsibility by those general practitioners who, in a time of shrinking resources, increasing need and ideologically inflated demand, refuse to engage in what is effectively bedside rationing.

The specious separation of health care and social care

The current Community Care arrangements are founded on the conviction that it is possible to distinguish between health and social care, but in reality the demarcation is illusory. Anyone who is so frail that they are unable to provide their own personal care has self-evident health needs. For general practitioners (and for patients) health and social care form a continuum and the debate about the distribution of responsibility and resources across the fictitious boundary is fundamentally flawed. Unfortunately the present state of the law decrees that health care should be provided free at the point of delivery whereas social care can be charged to the patient or their family. When resources are insufficient this leads to pressure to define needs as social and to pass the costs of care on to the patient.

The difficulties for the patient concern the well-recognised poverty trap and the emerging 'disability trap'. Charges for social care services are applied to anyone in possession of more than a very small capital sum, and this includes property even if it is still occupied by other members of the family. Those without capital and receiving Income Support have the full cost of their care provided but others, particularly those just above the threshold, face considerable difficulties. Families can find themselves faced with a sequence of losses, a parent's health followed by the family home.

The disability trap is even more insidious. Faced with inadequate resources, local authorities are having to choose between providing some level of input to large numbers of frail and dependent people or a more intensive and expensive service to only the most dependent. Most feel obliged to choose the latter with the result that people are denied help until they have fallen below a threshold which is set at a standard of care that many find quite unacceptable. Once services are provided, they are usually of a high standard but the phase of deterioration to the qualifying level is distressing, humiliating and destructive of families[10].

For doctors, and other members of the primary care team, efforts to deliver a high standard of health care in a context of inadequate social care often prove futile. The process is akin to trying to fill a bucket without a bottom and the net effect is to sap the morale of both patients and health workers.

Health promotion instead of health protection

The tidal wave of health promotion rhetoric seems, from my position in inner city general practice, to be an elaborate mechanism for blaming the victims[11]. In 1812, the poet Shelley described the same injustice[12]:

> *'The rich grind the poor into abjectness and then complain that they are abject.'*

Cigarette smoking is the key example. I believe that all my patients are now fully informed of the dangers of smoking. Sadly many continue to smoke because they lead lives which are so materially and emotionally constrained that cigarette smoking is one of pitifully few sources of pleasure and relief. All the evidence tells us that banning cigarette advertising would do more to reduce the levels of cigarette smoking in this

country than any other measure and yet it is not done, for purely fiscal reasons. Health differentials based on social class are blamed on lifestyle choices, the victims are blamed, and the responsibility for reducing cigarette smoking is passed to the general practitioner who must raise the subject, to the point of becoming very tedious, on every possible occasion[13]. Shah Ebrahim[14] draws the distinction between health promotion, which is a responsibility of health workers, and health protection, which is a responsibility of government. The government has pursued the rhetoric of health promotion to disguise its failure in the arena of health protection. Patients are deprived twice over; first by the absence of adequate health protection measures and then by the erosion of time within the consultation by the ever-increasing health promotion agenda[15].

All general practitioners, to a greater or lesser extent, are disturbed by these developments. We struggle with the ethical dilemmas they impose and we complain. They are eroding of the essential nature of general practice. Further, they distract us from the more fundamental questions which are at the heart of our unease. These questions are about the nature of medicine and our particular role as generalists within the larger endeavour of the discipline of medicine.

Notes and references

1 NHS Executive. *Developing NHS purchasing and GP fundholding.* Leeds: NHS Executive, 1994.
2 Metcalfe D. Care in the capital: what needs to be done. BMJ 1992; **305:** 1141-1144.
3 BMA Secretariat. *Core values for the medical profession in the 21st century.* London: BMA, 1995.
4 Joint Working Party of the Welsh Council of the Royal College of General Practitioners and the Welsh General Medical Services Committee. Patient care and the general practitioner. BMJ 1994; **309:** 1144-7.
5 Howie J. Personal communication 1990.

6 Dunstan GR. *Ideology, ethics and practice.* London: RCGP 1994.
7 McWhinney I. *A Textbook of Family Medicine.* Oxford: Oxford University Press 1989.
'Human variability is such that for a seriously ill person, the physician cannot be a replaceable part. If we insist on treating ourselves as such, we should not be surprised if society treats us as laborers rather than as professionals. We should also not be surprised if it does something to us as people. As we withdraw from our patients, we will be the poorer for it. Our professional lives will be less satisfying, and we will lose much of the depth of experience that medicine can give us.'
8 Veatch RM. Justice in health care: the contribution of Edmund Pellegrino. *J Med Phil* 1990; **15:** 269-87.
9 Calman K. The profession of medicine. BMJ 1994; 309: 1140-3.
10 Ellis K. *Squaring the circle: user and carer participation in needs assessment.* Joseph Rowntree Foundation
11 Marantz PR. Blaming the victim: the negative consequences of preventive medicine. *American Journal of Public Health* 1990; **80**(10): 1186-7
12 Quoted in Holmes R. *Shelley: the pursuit.* London: Weidenfeld & Nicolson, 1974.
13 Stott NCH, Kinnersley P, Rollnick S. The limits to health promotion. BMJ 1994; **309**: 971-2.
14 Ebrahim S. *Public health implications of ageing.* Milroy lecture: Royal College of Physicians 1994.
15 Sullivan F. Intruders in the consultation. *Family Practice* 1995; **12:** 66-69.

3
Nature of Medicine

3
Nature of Medicine

The story of medicine is one of striving to make sense of the human experience of illness. Patients who perceive themselves to be ill have always asked questions of the doctor[1] – 'Am I indeed ill?' ' Can I be cured?' 'Can my suffering be relieved?' 'Why has this happened to me?' 'What will happen to me now?' 'Will I die?' The enormous advances of scientific medicine over the last century have meant affirmative answers to the second question 'Can I be cured?' in more and more cases with much relief of suffering and prevention of premature death. However this has been at the cost of avoiding the other questions and the human need is for all the questions to be answered. Medicine is diminished by too narrow a definition of the discipline, in terms both of the nature of illness and disease, and of their causes.

The nature of illness and disease

Illness begins as a subjective sense of bodily unease, an experience of the functioning of the body as being not quite right[2]. It is often very intangible and the sense of unease arises not just from what we have come to recognise as disease but also from other forms of distress including tiredness and unhappiness, misery and grief. With the success of scientific medicine has come an emphasis on disease which has tended to invalidate the individual's experience of illness. Distress and unease which do not fit into a pattern of disease which science has taught us to recognise, are belittled and ignored.

The causes of illness and disease

The wider causes of illness and ultimately of

disease are also ignored in too narrow a definition of disease. Many doctors and politicians have been reluctant to recognise the power and extent of the socio-economic determinants of ill-health; the ways in which society functions to make its own members unwell through the stresses of poverty, poor housing, unemployment, pollution and lack of opportunity for worthwhile achievement. Ordinary people seem always to have known these things – ask them what is important to their health and they will mention housing, safety and opportunity for their children, adequate income and opportunities for work. Yet, 'The Health of the Nation'[3] minimised the impact of poverty[4] and completely failed to mention the influence of unemployment on health[5].

The myth of cure

The welcome success of scientific medicine carries other dangers. The chief of these is the implication, the false promise, that science offers a cure for every ill and the indefinite postponement of death[6]. Death, which is inevitable, and often, unpredictable, arbitrary and unjust, is seen more and more as a simple failure of medicine and doctors. Medicine cannot promise immortality and yet we, in Western society, begin to convince ourselves that it might. Neither does it promise the relief of all bodily discomfort and pain, and yet we become less and less tolerant of these and more convinced that we have a right to perfect health. Scientists and doctors carry a great responsibility for perpetuating these dangerous illusions[7], which serve to further damage, demoralise, stigmatise and disappoint victims of the many chronic diseases which can be treated but not cured and whose sufferers must often pay a high price in terms of discomfort, restrictions and inconvenience[8].

The emphasis on lifestyle risk factors for disease creates a climate of victim-blaming which adds a sense of guilt[9] to the

distress and terror suffered by those arbitrarily afflicted by serious disease. Arthur Kleinman[10] reminds us that:

> *'Cancer is an unsettling reminder of the obdurate grain of unpredictability and uncertainty and injustice – value questions, all – in the human condition.'*

Similarly intractable is the kind of chronic illness which seems to arise from profound and insoluble unhappiness, and manifests itself in, for example, continuous fatigue, aching muscles, insomnia, palpitations and frustration. Scientific medicine has offered so little here and its successes distract attention away from what might be achieved by a fairer, more equitable society within which the rewards of human life and endeavour would be more evenly shared.

The search for meaning

Where we cannot cure we must be available to help the patient to make some kind of sense of their suffering. In such circumstances, the need for answers to the last four questions becomes overwhelming. 'Can my suffering be relieved?' 'Why has this happened to me?' 'What will happen to me now?' 'Will I die?'

The general practitioner, often seeing patients through twenty or thirty years of illness and disease, both major and minor, as well as a series of significant life events, is in a unique position to help the patient make some kind of sense of what is happening to them. The key skill here is to listen and in so doing to allow the patient to find their own pattern and explanation. The doctor witnesses the suffering, the struggle and the fortitude of the patient and the relationship is one of solidarity. The patient is allowed and enabled to tell the story of their illness to the doctor during a succession of consultations which may extend over many years[11]. During this process the

patient's burden is shared and their experience is validated by being recounted to an external witness provided by society, in the person of the doctor[12].

Peter Toon[13] states:

> *'The consultation is the patient's forum for coming to understand her illness; not merely a rational understanding, but an understanding which involves the emotions and which contributes to the growth of the individual.'*

I have argued that the second illness question 'Can I be cured?' may be answered by scientific medicine. The first 'Am I indeed ill?' is the forum of co-operative endeavour between patient and general practitioner and provides the latter with a key role. The remaining four 'Can my suffering be relieved?' 'Why has this happened to me?' 'What will happen to me now?' 'Will I die?' are answered partly by science and partly within the search for meaning. Accompanying the patient in this search provides the doctor with another key role.

Notes and references

1 Helman CG. Disease versus illness in general practice. *J Roy Coll Gen Pract* 1981; **31:** 548-552. My questions are different but my debt clear.
2 Rudebeck CE. General practice and the dialogue of clinical practice: on symptoms, symptom presentations and bodily empathy. *Scand J Prim Health Care* Suppl 1/1992.
3 Department of Health. *The Health of the Nation: a stategy for health in England.* London: HMSO 1992.
4 Wilkinson RG. Income distribution and life expectancy. *BMJ* 1992; **304**: 165-8.
5 Beale N, Nethercott S. The nature of unemployment morbidity. *J Roy Coll Gen Pract* 1988; **38:** 197-202.
6 McCormick J. Fifty years of progress. *J Roy Coll Gen Pract* 1975; **25**: 9-19.

7 Tallis R. Medical advances and the future of old age. In: Marinker M, editor. *Controversies in health care policies: challenges to practice.* London: BMJ Publishing Group 1994.
8 Heaney S. *The Cure at Troy.* Derry: Field Day Theatre Company 1990.
9 Bennett MI, Bennett MB. The uses of hopelessness. *Am J Psychiatry* 1984; **141:** 559-562.
10 Kleinman A. *The illness narratives: suffering, healing and the human condition.* New York: Basic Books 1988.
11 Williams GH, Wood PN. Common-sense beliefs about illness: a mediating role for the doctor. *Lancet* 1986: 1435-7.
12 Berger J, Mohr J. *A Fortunate Man: the Story of a Country Doctor.* Harmondsworth: Allen Lane The Penguin Press 1967.
13 Toon P. *What is good general practice?* Occasional Paper 65. Exeter: RCGP, 1994.

4
The Key Roles of General Practice

4
The Key Roles of General Practice

In 1974, the Leeuwenhorst Working Party of European general practitioners devised the following familiar description of general practice:

'The general practitioner is a licensed medical graduate who gives care to individuals, irrespective of age, sex and illness. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors in his considerations about health and illness. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practice in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognize that he also has a professional responsibility to the community.'

This definition is trapped in its time by its irritating use of an exclusive pronoun and by its lack of reference to cultural factors but it remains a useful definition to which we continue to aspire. Taken together with the original, absurdly idealistic, 1946 WHO definition of health as:

'a state of complete physical, mental and social well

being,[1] and not merely the absence of disease or infirmity.'

it underpins the essential generalism of general practitioner care. All aspects of human existence are legitimate concerns of the general practitioner provided that they are presented as a problem by the patient. This means that the general practitioner is obliged to deal with the complexity of each individual patient and should never be content to respond to a patient by saying "That's not my business or my problem"[2]. Each person and each context is unique and this is the joy and the challenge of general practitioner care.

Making full use of this breadth, the key roles of the general practitioner are firstly to serve as interpreter and guardian at the interface between illness and disease; and secondly to serve as a witness to the patient's experience of illness and disease.

The pivotal position of British general practice arose out of a nineteenth century trade demarcation dispute between physicians and surgeons on the one hand and apothecaries on the other[3]. The physicians and surgeons gained absolute control of the great hospitals being built in every major city by letting the apothecaries have the patients. This was done by instituting the referral process by which the hospital specialists agreed only to see patients who were referred to them by the generalist apothecaries. This fortuitous outcome has been one of the great successes of the British health care system and the foundation of its widely recognised cost-effectiveness. Systems which have developed without a referral process between generalist and specialist have now recognised the need to create one. Specialist care is vastly more expensive than generalist care and by controlling access via a generalist who is able to treat 90% of all illness episodes presented, costs can be much more effectively contained[4].

The cost effectiveness of this boundary between generalist and specialist is recognised and valued but the importance of the interface between illness and disease is much less

understood. This is the point at which the vast undifferentiated mass of human distress and suffering meets the theoretical structures of scientific medicine and the social sciences which have been developed to enable humanity, to a still very limited extent, to understand and control the experience of illness. The illness is the patient's perception of something being wrong, the sense of unease in the functioning of the body or mind; the disease is a defined entity which offers the benefits and risks of scientific medicine. Illness is what the patient has on their way to see the doctor and a disease is what they have on the way home. The former is subjective, the latter objective. Most disease involves illness, but by no means all illness involves disease. Both the disease and the illness can be more or less serious. The task of the general practitioner is to make these distinctions and to diagnose disease, to refer serious treatable disease to specialist colleagues, to treat less serious disease and to acknowledge and witness the suffering brought by illness.

Interpretation at the interface between illness and disease offers the answer to the first question: 'Am I ill?', and the implicit supplementary questions: 'And might I be so ill that I might die?', 'Or am I just distressed?' The way the construction of the words overlaps is fascinating – dis-ease, un-ease, dis-stress, stress. The over-enthusiastic interpretation of illness as disease, borne of inexperience or fear of litigation, leaves patients open to the dangers but not the benefits of scientific medicine. Arthur Kleinman[5] writes:

> *'The physician's training also encourages the dangerous fallacy of over-literal interpretation of accounts best understood metaphorically.'*

The demise of religious and philosophical explanations for the arbitrariness of human suffering has left the modern world with limited means of understanding and coping. Illness is one of the few valid outlets for human distress. But if that illness is

wrongly interpreted as disease all kinds of damage can be done. Thus the first role includes elements of both interpreter and guardian[6]. The general practitioner as interpreter engages the patient in the necessary dialogue. The general practitioner as guardian safeguards the patient from the too ready interpretation of illness as disease. This guardian role is a parallel and prerequisite to the more widely acknowledged role as gatekeeper between primary and secondary care.

Carl Edvard Rudebeck[7], has developed this argument further. He defines the core skill of general practice as bodily empathy. This is the ability to identify imaginatively with the patient's subjective experience of illness to provide genuine recognition and validation of that experience. Only if the patient can believe that their experience is understood at a fundamental level by the doctor will that patient be able to trust in the doctor's interpretation of their illness. He distinguishes the subjective experience of 'body-as-self' from the objective experience of 'body-as-nature'. As doctors, we combine the subjective experience of our own bodies and minds, with the objective theoretical understanding of the science of their working. By straddling this divide within his or her own body, the generalist doctor is qualified to interpret the interface between illness and disease.[8]

The depth of understanding involved in this interpretation begins the process of witnessing in which the doctor works with the patient to make sense of the patient's experience of both illness and disease in the context of the rest of their lives. This is what Peter Toon has called the hermeneutic role[9], and Marshall Marinker, the biographic role[3]. All of us need our experience and, most of all, our sufferings to be acknowledged and given value; we need to tell our stories and have them heard. As doctors we enjoy the enormous privilege of witnessing the experience not only of our own lives but parts of those of all our patients.

The last of the illness questions is 'Will I die?' and an essential test of the doctor is to what extent we are prepared to accompany the patient in their search for an answer. Scientific medicine has allowed doctors to escape from their traditional role as 'the familiar of death', but to do so is to betray the role of witness. John Berger recognises this:

> *'The doctor is the familiar of death. When we call for a doctor, we are asking him to cure us and to relieve our suffering, but, if he cannot cure us, we are also asking him to witness our dying. The value of the witness is that he has seen so many others die. ... He is the living intermediary between us and the multitudinous dead. He belongs to us and he has belonged to them. And the hard but real comfort which they offer through him is still that of fraternity.'*

Petr Skrabanek has argued that we have lost touch with the art of dying[10] coincident with beginning to value longevity more than the intensity of the experience of living. He quotes John Stuart Mill's 'Utility of Religion':

> *'It is not, naturally and generally, the happy who are most anxious either for prolongation of the present life or for a life hereafter; it is those who have never been happy.'*

By refamiliarising ourselves with death, we can undo some of the mischievous damage that science has done with its illusory promise of immortality. We have an obligation to debate with our patients and society the limitations as well as the possibilities of medicine.[11]

The consultation

The consultation is the foundation of general

practice:

> *'– the occasion when in the intimacy of the consulting room, or the sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts.'*[12]

This occasion provides the opportunity for the patient's story to be heard and for their experience to be acknowledged. If this is done well the enormous benefits of scientific medicine can be made available and the dangers minimised. Julian Tudor Hart[13] moves beyond the rather paternalistic notion of advice and describes the consultation as a unit of production enacted between two co-producers of health – the patient and the doctor – in a meeting of experts. He writes:

> *'Unless consultations are understood as the points of production of critically important decisions which determine all other consumptions, the cost-effectiveness of the entire NHS will fall in terms of net health gain, even if it improves in terms of reduced waiting times or raised outputs of technical procedures. The quality of consultations must in large part depend on freedom from time pressures, without perverse incentives to save time by ill-considered somatisation, prescription or referral, and with protected time in which to develop patients' capacities as producers rather than consumers.'*

The consultation provides the setting for the key transactions of general practice. I have argued that the key roles are to serve as an interpreter and guardian at the interface between illness and disease, and to serve as a witness to the illness experience. These roles discharge a crucial social function to the extent that, in circumstances when they are unfilled, the individual and collective experience of illness and disease is harsher and more lonely, and humanity is the meaner[14]. These key roles of

general practice require a particular combination of skills and circumstances, the continued availability of which is necessary to the survival of the discipline.

Notes and references

1 With justification, this has been mocked by Skrabanek as:
'The sort of feeling ordinary people may achieve fleetingly during orgasm, or when high on drugs.'
Skrabanek P. The Death of Humane Medicine and the Rise of Coercive Healthism. Social Affairs Unit, London, 1994.

2 McWhinney IR. A textbook of family medicine. New York: Oxford University Press, 1989.
'Family medicine does not separate disease from person or person from environment'.

3 Marinker M. *The end of general practice.* Bayliss lecture: Royal College of Physicians 1994.

4 Fry J, Horder J. *Primary health care in an international context.* London: Nuffield Provincial Hospitals Trust, 1994.

5 Kleinman A. *The illness narratives: suffering, healing and the human condition.* New York: Basic Books 1988.

6 Heath I. The future of general practice. In: Lock S, ed. *Eighty-five not out: essays to honour Sir George Godber* London: King Edward's Hospital Fund for London, 1993.

7 Rudebeck CE. General practice and the dialogue of clinical practice: on symptoms, symptom presentations and bodily empathy. *Scand J Prim Health Care* Suppl 1/1992.

8 Berger J, Mohr J. *A Fortunate Man: the Story of a Country Doctor.* Harmondsworth: Allen Lane The Penguin Press 1967.
'– it is the doctor's acceptance of what the patient tells him and the accuracy of his appreciation as he suggests how different parts of his life may fit together, it is this which then persuades the patient that he and the doctor and other men are comparable because whatever he says of himself or his fears or his fantasies seems to be at least as familiar to the doctor as to him. He is no longer an exception. He can be recognised. And this is the prerequisite for cure or adaptation.'

9 Toon P. *What is good general practice?* Occasional Paper 65. Exeter: RCGP, 1994.

10 Ignatieff M. *The Needs of Strangers*. London: Chatto & Windus 1984. *'Most other cultures, including many primitive ones whom we have subjugated to our reason and our technology, enfold their members in an art of dying as in an art of living. But we have left these awesome tasks of culture to private choice.'*
11 Armstrong EM. We must not let science blind us. BMA News Review 1995, March 8.
12 Spence J. *The purpose and practice of medicine*. Oxford: Oxford University Press 1960.
13 Hart JT. *Feasible socialism: the National Health Service, past, present and future*. London: Socialist Health Association, 1994.
14 Thomasma DC. Establishing the moral basis of medicine: Edmund D Pellegrino's philosophy of medicine. *J Med Philosophy* 1990; **15:** 245-67.

5
What is needed

5
What is needed

The consultation brings together the human experience of suffering and the paradigms of scientific medicine, with the general practitioner acting as an interpreter at the boundary between illness and disease, and a witness to suffering. In order to fulfill these roles effectively, general practitioners must work from a firm foundation of clinical competence. Without this, we betray our patients' trust and become dangerous. Beyond it, we need generalism, continuity, empathy, words, partisanship, time and trust.

We must be generalists acknowledging all forms of distress as legitimate, and we need to be able to provide continuity of care over time. We must have the time and the skill to listen and to hear, to the extent of being able to empathise, so the patient feels understood and is able to trust. We need to be able to find words which demonstrate our understanding. We must become partisans, consistently choosing to side with our patients.

As general practitioners, we need the ability to identify imaginatively with a wide range of individuals. To achieve this we need to avail ourselves of as wide an experience of humanity as possible[1], and borrow skills from other disciplines[2]. We must make available the benefits of scientific medicine but mitigate its dangers through an understanding of anthropology, biography, poetry, myth, philosophy and politics. The skills of anthropology and biography help us with empathy and the use of continuity, and an awareness of poetry and myth can help us find the words to communicate our understanding to the patient. A grasp of philosophy and politics can show us how to be effective partisans on behalf of our patients.

Shared history, biography and anthropology

Richard Holmes, the biographer of Shelley and Coleridge, has described the need for everyone to tell their story[3] and to have it valued.

> *'I learned how much everyone needs to talk about their own past, the forces and experiences that shaped them; and how rarely this constant need is satisfied in the competitive, pressurised world, except in moments of emotional crisis.'*

and:

> *'... the lives of great artists and poets and writers are not, after all, so extraordinary by comparison with everyone else. Once known in any detail and any scope, every life is something extraordinary, full of particular drama and tension and surprise, often containing unimagined degrees of suffering or heroism, and invariably touching extreme moments of triumph and despair, though frequently unexpressed. The difference lies in the extent to which one is eventually recorded, and the other is eventually forgotten.'*

This resonates so clearly with the experience of general practice. To a greater or lesser degree, we all serve as the biographers of our patients[4], of that portion of their lives which they choose to share with us.

I have been in practice in Kentish Town in north London since 1975 and in that time I have moved, alongside some of my patients, from my 20s to my 40s. We have been replaced by those I first knew as babies. Other patients have moved from their 40s to their 60s or from their 60s to their 80s. These are progressions which involve many changes and much experience, and over the years these patients have shared their

histories with me. In a professional span of 35 years, a general practitioner can expect to see patients through almost half a lifetime and this continuity is a powerful tool[5]. It contrasts sharply with the contemporary world of short-term contracts and episodic care. Within this new world, managers, who increasingly define our working conditions, are almost all on short-term contracts and setting themselves increasingly short-term objectives. Health workers are judged in terms of their caseload throughput and by the number of completed episodes of care they deliver. General practitioners are now almost unique in being spared the pressure to discharge patients from a caseload. We alone retain the benefit of continuity and remain free to work within the extended timescale of chronic illness.

General practitioners are privileged to have a part in their patients' experience of family changes, retirement from work, move of home, illness, death and loss. This shared experience forms a bond of trust and respect which is mutual and earned over time. This trust allows the doctor and the patient to work together in their task of making sense of illness experience[6]. It also provides the context for the diagnosis of disease. It is only by following the patient through the whole of their illness experience, both the mundane and the extraordinary, that we can hope to recognise the serious diagnosis "lurking in the shadow cast by ... interminable complaining"[7]. It is the ability to recognise that, on this occasion, the complaint is qualitatively different.

Words, poetry and myth

The meanings of illness, the threat, the fear, the suffering and the endurance can only be interpreted, ordered and contained if both doctors and patients can find and agree on the right words. Michael Ignatieff[8] writes:

'We need words to keep us human. ... Our needs are made

of words: they come to us in speech, and they die for lack of expression. Without a public language to help us find our own words, our needs will dry up in silence. It is words only, the common meanings they bear, which give me the right to speak in the name of the strangers at my door. Without a language adequate to this moment we risk losing ourselves in resignation towards the portion of life which has been allotted to us. Without the light of language, we risk becoming strangers to our better selves.'

By expression in words the communication between doctor and patient becomes explicit. Only if the doctor can find words which the patient recognises as describing his or her own experience, can the patient be certain that he or she has been understood.

There are strong parallels with poetry and we have much to learn from poets, with whom we share:

'... the desire to witness exactly.'[9]

Seamus Heaney describes poetry as:

'... a point of entry into the buried life of the feelings or as a point of exit for it. Words themselves are doors; Janus is to a certain extent their deity, looking back to a ramification of roots and associations and forward to a clarification of sense and meaning.'[10]

And he describes the poet as being credited:

'with a power to open unexpected and unedited communications between our nature and the nature of the reality we inhabit.'

Robert Frost asserts that the true poem:

'ends in a clarification of life – not necessarily a great

> *clarification, such as sects and cults are founded on, but in a momentary stay against confusion.'* [11]

Sometimes, working together, the doctor and the patient can also find the understanding and the words to provide this momentary stay against confusion and, in so doing, much relief of suffering.

Novelists, too, have much to offer doctors. Our experience of humanity is expanded with each patient contact, but, in reading a novel we are offered aspects of the same human experience given breadth and depth by the expressive ability of the writer, which are the same dimensions which we seek to pursue with our patients. Reading, we come across passages which invoke particular individual patients, and allow us to see and understand them at a new depth. For example, in 'The Conservationist', Nadine Gordimer writes:

> *'Distress is a compulsion to examine minutely – this anguished restless necessity, when something can't be undone, when there's nothing to be done, to keep going over and over the same ground.'*

This is a perfectly precise description of the futile repetitiveness of regret and it has given me a form of words which I have been able to use to show the patient who is trapped in this distress that their suffering is understood.

Those of us lucky enough to lead lives of personal good fortune need writers to make us understand the reality of lives of privation and loss. Novelists can also help us across boundaries, take us into other cultures and provide us with insight into the experience of patients struggling to survive and communicate across barriers of language and culture.

> *'Lily herself enjoyed good health; fortunately for both of them, she often thought. Until Man Kee had arrived neither had been to a doctor in their time in the UK.*

Some of the other restaurant employees went to a Cantonese-speaking Indian doctor in Southall if they were seriously ill. But Lily, even now, still felt it mildly disgraceful to take something for nothing. Chen was also puzzled by this business of registering and form-filling. He had once seen a medical card. The size of the number had been enough to intimidate him.'

Timothy Mo
Sour Sweet

Novels tell us stories and those stories resonate to a greater or lesser extent with our own, but the most potent and disturbing resonances are to be found in myth. George Steiner[12] raises the possibility that the power and persistence of the primordial myths derives from their origin alongside the development of language, of the way we use words. He argues:

'That mythology and the bone-structure of syntax are somehow interwoven.'

As an example he speculates that the invention of future tenses:

'might correspond to the invention of hope, of certain tools and techniques of anticipatory cultivation – the sowing of seed towards a subsequent harvest –'

He continues:

'Nothing is more astounding in our resources of syntax than the evolution of optatives, of subjunctives, of counter-factual propositions. What complex worlds of reasoned imagining underwrite sentences beginning with 'if': if Napoleon had won at Waterloo, if we discover a remedy to Aids, if there had been no Mozart. Such sentences say "No" to reality, they allow us to inhabit

manifold orders of possibility, to dream argumentatively.'

In this way, myths give us our most powerful metaphors, a guide to the exploration of our deepest, most ancient and most disturbing feelings, and clues in the search for meaning in human illness.

This century has seen the first literate generations to grow up within Western culture without an intimate knowledge of these myths. At school, I resented deeply being obliged to learn Latin and was relieved not to be force-fed Classical Greek, but I now regret my lack of familiarity with the stories. Why did we stop telling the stories when we stopped learning the archaic languages? We have lost the mythological framework which has the potential to give universality to our individual experience and we are the poorer for it[13]. Mary Midgeley writes:

> *'We understand today that it is a bad idea to exterminate the natural fauna of the human gut. But trying to exterminate the natural fauna and flora of the human imagination is perhaps no more sensible. We have a choice of what myths, what visions we will use to help us understand the physical world. We do not have a choice of understanding it without using any myths or visions at all. Again, we have a real choice between becoming aware of these myths and ignoring them. If we ignore them, we travel blindly inside myths and visions which are largely provided by other people. This makes it much harder to know where we are going.'*

The ancient myths range across the whole of human aspiration, from the most noble to the most base, but always valuing the intensity of life more than its length[14]. They tell us all we need to know to make sense of the risks our patients take and the price they are prepared to pay for those risks. Set in this dense context, the emptiness of much health promotion rhetoric is plain.

Partisanship, philosophy and politics

The general practitioner must strive to be always, vehemently, on the side of the individual patient, witnessing, and sometimes interpreting, their distress. Only by seeking to identify fully with the patient's predicament can the doctor understand. Through this process of empathic identification, the doctor is engaged to serve as the patient's advocate. Edmund Pellegrino has argued the philosophical basis of this position[15]:

> *'It is not just that hippocratic professional ethics lacks a theory of just distribution; it is rather that it is committed to the proposition that societal goods do not count ethically. The commitment of the clinician is not just primarily to the patient, it is fully patient-centered. Considering the common good is not an add-on; it is morally wrong.'*

The role of individual advocate underpins all else, but the general practitioner combines this with a wider social and political responsibility to speak out on behalf of the most needy and least heard. Robin Downie, seeking to answer the evaluative question of what enables professions to perform a unique and socially valuable function, distinct from business and commerce, describes six characteristics of a profession[16]. The third of these involves the duty to speak out on matters of social justice and social utility. Illustrating this characteristic, he writes:

> *'... Doctors have a duty to speak out on broad issues of health, as for example they might speak out against cigarette advertising or cast doubt on the feasibility of medical services in the event of a nuclear attack.'*

General practitioners are in a privileged position to develop an intimate knowledge of their patients' lives. Those working in areas of socio-economic deprivation are made acutely and

repeatedly aware of how squalid overcrowded housing conditions, homelessness, unemployment and poverty undermine the autonomy, dignity, self-respect and health of those who suffer them[17]. We see, every day, how society functions in a way which systematically undermines the health of its most vulnerable members. We have a duty to speak out about this because it represents a denial of social justice[18]. Further, we have a responsibility to contribute to the research which makes the links between health and socio-economic conditions explicit and to disseminate that research throughout society. If we can define the social conditions which cause ill-health, we begin to define the social changes which will prevent and treat it[19]. We should not shirk that responsibility. I have argued that the general practitioner has the responsibility to approach each individual patient with unconditional positive regard and to become his or her advocate in the face of illness. Equally, the general practitioner has a responsibility to serve as an advocate for those whose health is chronically undermined either by disease or by their adverse life circumstances. Only in this way can equity be achieved and Julian Tudor Hart's Inverse Care Law[20] be reversed.

Time, trust and 'the materialistic mire of market medicine'[21]

As general practitioners, we can do nothing for our patients if we lack time to spend with them and if we fail to gain and retain their trust. Time and trust are fundamental to our endeavours and both are being undermined in the current crisis. The demands of health promotion, patient care which was previously undertaken in hospital, care in the community, and purchasing in the NHS market, all seriously undermine the availability of time to be spent with patients. The conflict, between the doctor's role as an advocate for the individual

patient and his or her increasing responsibility for the allocation of scarce resources across a population, threatens to undermine the trust of patients. With the introduction of market values into the National Health Service, doctors have colluded in arguments that resources for health are necessarily insufficient and have been seduced into accepting responsibility for decisions about the allocation of these scarce resources. However, such decisions are not medical but political and they should be taken by those members of society who can be held democratically accountable for them. The individual patient seeking the advice of a general practitioner must be able to believe that the doctor is acting entirely in that patient's interest. As soon as the patient begins to suspect that a test or a hospital referral is being withheld for budgetary reasons and not because it is unnecessary, the patient's trust will be lost and the whole cost-effectiveness of British general practice will evaporate. Patients will insist on inappropriate interventions because they are afraid and the general practitioner, having lost the patient's trust, will be unable to reassure them. Once lost, trust will be immensely difficult to regain.

I have described two key but apparently undervalued roles of general practice and I have attempted to show that there are certain requirements for the effective performance of these roles. In discussing these requirements, I have been brought back to some of the components of the current crisis because these are threatening the essential prerequisites of good practice.

Notes and references

1 Midgeley M. *Science as Salvation: a modern myth and its meaning.* London: Routledge 1992.
'And since people's deepest ideas about the meaning or meaninglessness of life are largely forged in everyday life and in the arts, we would surely do well to pay serious attention to these wherever we can find them.'

2 Sanders K. *Nine Lives: the emotional experience in general practice.* The Roland Harris Education Trust 1991.
'– the courage and the imagination to permit a marriage between art and science. When they are separated, both remain sterile. In combination, they complement one another in an enhanced desire to find meaning in the experience of being alive.'
3 Holmes R. *Footsteps: adventures of a romantic biographer.* London: Hodder and Stoughton 1985.
4 Kleinman A. *The illness narratives: suffering, healing and the human condition.* New York: Basic Books 1988.
''Another core clinical task is the empathetic interpretation of a life story that makes over the illness into the subject matter of a biography. Here the clinician listens to the sick individual's personal myth, a story that gives shape to an illness so as to distance an otherwise fearsome reality. The clinician attends to the patient's and family's summation of life's trials. Their narrative highlights core life themes – for example, injustice, courage, personal victory against the odds – for whose prosecution the details of illness supply evidence.'
5 Wynne-Jones M. General practice: a job for life? *BMJ* 1993; **307**: 630.
'I left patients with whom I shared an irreplaceable past, underestimating its importance. Changing practices means throwing away the investment of many years' effort.'
6 Berger J, Mohr J. *A Fortunate Man: the Story of a Country Doctor.* Harmondsworth: Allen Lane The Penguin Press 1967.
'He does more than treat them when they are ill; he is the objective witness of their lives. ... He keeps the records so that, from time to time, they can consult them themselves. ... He represents them, becomes their objective (as opposed to subjective) memory, because he represents their lost possibility of understanding and relating to the outside world, and because he also represents some of what they know but cannot think.'
7 Marinker M. *The end of general practice.* Bayliss lecture: Royal College of Physicians 1994.
8 Ignatieff M. *The Needs of Strangers.* London: Chatto & Windus 1984.
9 Heaney S. *The Government of the Tongue.* London: Faber and Faber 1988.
10 Heaney S. *Preoccupations: Selected Prose 1968-1978.* London: Faber and Faber 1980.
11 Quoted in Heaney S. *The Government of the Tongue.* London: Faber and Faber 1988.
12 Steiner G. *The Europe Myth.* Salzburger Festspiele 1994.

13 Berger J, Mohr J. *A Fortunate Man: the Story of a Country Doctor.* Harmondsworth: Allen Lane The Penguin Press 1967.
'The culturally deprived have far fewer ways of recognising themselves. A great deal of their experience – especially emotional and introspective experience – has to remain unnamed for them.'
14 Calasso R. *The Marriage of Cadmus and Harmony.* London: Jonathan Cape 1993.
'The Greeks had no inclination for temperance. They knew that excess is divine, and that the divine overwhelms life. But the more they found themselves immersed in the divine, the more they wished to keep it at arm's length. Western sobriety, which two thousand years later would become everyman's common sense, was at first no more than a mirage glimpsed through the tempest of the elements.'
15 Veatch RM. Justice in health care: the contribution of Edmund Pellegrino. *J Med Phil* 1990; **15**: 269-87.
16 Downie RS. Professions and professionalism. *Journal of Philosophy of Education* 1990; **24**: 147-159.
17 Bartley M. Health costs of social injustice. *BMJ* 1994; **309**: 1177-8.
18 Watt GCM. Health implications of putting value added tax on fuel. *BMJ* 1994; **309**: 1030-1.
19 Kleinman A. *The illness narratives: suffering, healing and the human condition.* New York: Basic Books 1988.
'Both cancer and heart disease intensify our awareness of the dangers of our times and of the man-made sources of much misery. But the governmental response is meant to obfuscate this vision of sickness as meaning something is wrong with the social order and to replace (medicalize) it with narrowly technical questions. Is there a better mirror of what we are about?'
20 Hart JT. The Inverse Care Law. *Lancet* 1971; i: 405-412.
21 Morell D. *Diagnosis in general practice: art or science?* London: Nuffield Provincial Hospitals Trust, 1993.

6
The future

6
The future

I have argued that the general practitioner has two key roles: one as an interpreter and guardian at the interface between illness and disease, the other as witness to the human experience of, and search for meaning in, both illness and disease. The first is a role which belongs to general practice, the second is shared with our specialist colleagues although continuity of care over time gives much more scope for it in general practice. I have attempted to show that these two roles justify the continuation of general practice in its present form, and that we should not allow them to be displaced, and the nature of general practice changed fundamentally, by the multiplicity of new roles we are being invited to try. Carl Edvard Rudebeck[1] asserts, rightly:

> *'Beliefs do not convince opponents, especially if these see a danger of losing resources. Logical arguments, catching the specific contribution of general practice to medicine and uniting the individual practitioners into a distinct profession, are essential.'*

The first key role is easier to justify by logical argument. Although less well understood than the role of gatekeeper to expensive secondary care, it is the other major component of the cost-effectiveness of British general practice. By identifying illness, a sense of bodily unease, as being due to distress rather than disease, we spare the individual patient unnecessary anxiety, tests and treatment, and also save the health service the financial costs of these.

The second role is harder to justify because, as John Berger has argued[2], its value depends, at least in part, on the worth we attach to an ordinary human life.

'... we in our society do not know how to acknowledge, to measure the contribution of an ordinary working doctor. ... when we imaginatively try to take the measure of a man doing no more and no less than easing – and occasionally saving – the lives of a few thousand of our contemporaries. Naturally we count it, in principle, a good thing. But fully to take the measure of it, we have to come to some conclusion about the value of these lives to us now. ... I do not claim to know what human life is worth – the question cannot be answered by word but only by action, by the creation of a more humane society. All that I do know is that our present society wastes and, by the slow draining process of enforced hypocrisy, empties most of the lives which it does not destroy: and that, within its own terms, a doctor who has passed the stage of selling cures, either directly to the patient or through the agency of a state service, is unassessable.'

All this is true and is part of the difficulty that we have in justifying ourselves and that our society has in valuing what we have to offer. There is an urgent need to debate these matters, to come to a view as to how highly we should all value the complex tasks of making the human experience of illness and disease less lonely. But first we have to rediscover a set of values which go beyond the numerical and the financial.

Meanwhile, there are other potential benefits in the careful witnessing of the processes of illness and disease. Our patients' stories contain the secrets, the mysteries, of the beginning of illness and within that the beginning of disease. The great contribution of general practice in the future may be in qualitative research[3], developing what David Metcalfe describes as the 'rigorous qualitative methods [which] are needed to elucidate the 'why' of situations described in quantitative terms'. Much general practice research has suffered through seeking the approbation of specialist colleagues in academic

medicine. The task ahead will demand more breadth and flexibility in the definition of academic respectability which is still embedded in the requirements of scientific biomechanical medicine. As Carl Edvard Rudebeck states:

> *'According to this view, an answer should be numeric, otherwise it is not a real answer. If, on the other hand, research is looked upon as an activity adding to or changing our prevailing comprehension of reality through the refinement of observations or experience, then the range of issues may be considerably widened. ... The evaluation of the quality of research at one instant and according to very strict formal criteria which may seem necessary from editorial points of view, is somewhat contradictory to the process of knowledge production itself.'*

I have argued that the complex mysterious depths of general practice fulfil functions which are beneficial both to individual patients and to the wider cause of human endeavour. Some contend that the wider dissemination of medical knowledge through the application of information technology, combined with the rise of consumerism within a less hierarchical, although perversely more socio-economically divided, society, will change fundamentally the relationship between doctor and patient[4]. However the demands and rights which drive the consumer relationship offer little prospect of containing the expressed or hidden fears which are implicit in almost every medical encounter[5]. Likewise any doctor who has faced serious illness knows that medical knowledge is similarly ineffective. On the other hand, it seems certain that the rapid progress of medical technology will mean that it will be possible to deliver, closer to patients' homes, complex treatments which were previously available only in hospitals. This could be done by enabling specialists to work outside hospitals while retaining a

clearcut referral process. The danger is that it will be done by taking work away from specialists and overloading general practitioners. If this happens, general practitioners will no longer have the time to serve as guardians of the interface between illness and disease, or indeed, as gatekeepers between primary and secondary care, with the result that the whole basis of the cost-effectiveness of the UK system of health care will disappear.

The effects of the current changes are enormously destructive. Yet people are beginning to talk of 'change fatigue' and to argue that even if things are bad, nothing radical should be done to remedy the situation because further change could not be endured. This cannot be right. Many of us believe deeply that the recent changes have been at best misguided, and at worst malevolent. We are holding out for a better, more compassionate, future. If the present situation is destructive and will continue to be so, we must seek to work with policy-makers and patients to rectify it.

General practice is a power for good but it is threatened by the process of accelerating change and will only have a future if it can explain and justify itself. There is an urgent need for the value of the key roles to be discussed with students[6], young doctors and the society we all seek to serve. Only through teaching do we make our own understanding explicit[7]. Without sharing that understanding, we risk losing something immensely precious.

Notes and references

1 Rudebeck CE. General practice and the dialogue of clinical practice: on symptoms, symptom presentations and bodily empathy. *Scand J Prim Health Care* Suppl 1/1992.

2 Berger J, Mohr J. *A Fortunate Man: the Story of a Country Doctor.* Harmondsworth: Allen Lane The Penguin Press 1967.

3 Murphy E, Mattson B. Qualitative research and family practice: a marriage made in heaven? *Family practice* 1992; **9**: 85-91.
4 Kernick DP. General practice's last stand. *BMJ* 1995; **310**: 1613.
5 Thomasma DC. Establishing the moral basis of medicine: Edmund D Pellegrino's philosophy of medicine. *J Med Philosophy* 1990; **15**: 245-67.
'– the instinctive resistance practising physicians often have towards overemphasizing autonomy in the doctor-patient relationship. One cannot abandon persons to their autonomy when they are in difficult straits.'
6 Marinker M. 2010. *J R Coll Gen Pract* 1981; **31**: 540-6.
7 Stevens J. Brief encounter. *J Roy Coll Gen Pract* 1974; **24**: 5-22.