Focus

Converse and celebrate your freedom

RNZCGP 1999 Oration by Wellington GP Marjan Kljakovic

I have heard it said many times that general practice is doomed. GPs worry about the fragmentation of their work. The loss of obstetric care is the latest bit that seems to have disappeared. I am certain general practice will change, and that GPs will survive.

I will tell my story about survival by first commenting on our history of fragmentation. Next, I will describe those features in our work that are important and ensure our survival. Finally, I will indicate how our freedom will help us survive.

History of change

We will know about our survival when we look at our history. I have asked historians; what were GPs like in 1899? They tell me there are no systematic stories about the clinical and social concerns. The little we do know is that all doctors in New Zealand were GPs, the majority went overseas for medical training, and few of them were female.

So what has changed in the last 100 years? The most dramatic change has been the steady fragmentation of the work done by GPs. The biggest split occurred over the first 50 years of this century, when many young GPs decided to become hospital specialists. This change occurred for the best of reasons.

Hospital doctors developed technologies that helped patients with specific problems, eg, the development of the x-ray machine occurred in this century and, as well all know, was very successful. The GPs remaining in the community were not involved in this success. The split between the hospital doctor and the GP would develop the skills needed for referral and the hospital doctor would develop the skill of advertising the technology.

Smaller fragments have fallen away from general practice over the last 50 years. Some of these fragments are viewed by GPs in a negative light, whereas others are seen as a natural aspect of modern general practice. Negative examples include maternity care, family planning, men's health, menopausal health, teenage health, sports medicine and travel medicine. Doctors who practise medicine within these areas concentrate their expertise in a similar fashion to what happens in the hospital setting.

GPs lament the loss of these fragments because they fear a loss of integration and continuity of care. A person could attend many different clinics and miss the kind of doctor who can provide holistic care.

Positive fragmentation

Other kinds of fragmentations have been seen as positive. A striking example is the splitting of postgraduate medical education. New Zealand GPs have split off from

other kinds of specialist medical education to develop their own skills and this has benefited patient care. Overseas travel is not as necessary as it might have been 100 years ago. We travel for fun, rather than for educational needs.

Another positive change occurred in the gender ratio of GPs. There were virtually no female GPs in 1899 and now 40 per cent of GPs are women.[1] Patients appreciate this change because they like to be able to choose the gender of a GP.

I have mentioned some things that have been added to and taken away from general practice over the last 100 years. GPs worry about them. Some argue that, if their work continues to fragment so much, then perhaps one day they will end up with nothing left to do. I disagree.

General practice has changed, but there are core features that have survived fragmentation since 1899. Survival matters. We should not confuse change with failure to survive. So, what are the essentials in general practice that survive through all the changes? There are just three that matter. One is the management of information. The next is the art of touching bodies. Finally, the conversations GPs have with their patients. I argue these three features will survive to 2099.

Managing information

Let me begin by talking about information. The act of managing information was not really much of an issue until about 15 years ago when a computer was cheap to buy and GPs were happy to place one in front of their receptionists. This ever-patient woman had to learn very quickly that GPs liked the new computer. She had to cope with the boss' enthusiasm for a new gadget. GPs spoke lyrically about how the computer revolutionised administration and financial matters in the practice.

Next in line was the practice nurse. These long-suffering women had to learn to merge the age-sex register database with the recall system to do immunisations and smear tests. Today, a quarter of GPs cope with computers in their day to day work compared to nearly all receptionists and practice nurses.

Why were GPs the last people in their practice to have a computer on their desk? I suspect the reason is that in their heart of hearts they cannot see how having a computer helps to be a good GP.

Reducing uncertainty

Good GPs are those who revel in managing uncertainty. Our hearts are won over when we realise computers help manage that uncertainty.

The uncertainty in our work is created by difficult intellectual problems patients ask us to manage. This uncertainty becomes acute when we appreciate the sheer volume of new information created in medicine every day. It is growing all the time. The computer helps us to reduce uncertainty for our patients by providing the right information, in the right way, at the right moment.

Look at the Palm computer. For less than $1000, it stores names, address, age, sex, phone number and any other matter you would like to write about your patient. It recognises your handwriting with a pen. It can send and receive email. It has an accounting package. You carry it in your pocket to house calls. It can talk to the computer on your desk with the push of a button.

This kind of computer will develop in the next century because it can be tailored to the personal needs of the user. Imagine it. We could allow patients to email their uncertainty, knowing that the message will get to the gadget sitting in our pockets. Your face-to-face consultation would have the added value of less uncertainty to manage. We are surely looking for new ways of adding value to our consultations.

Information management is a valuable skill. GPs do it rather well. The present structures of general practice cope with the way it has been done for the last 100 years. But things always change and information management is no different. We need to change as well if we are to remain good managers of information.

We will cope when patients start to keep their own records on the Internet and only the select few may enter their sites. We will be one of the few. Why? We will be one of the evidence-based medicine experts. Our skill in manipulating health information to answer our patients' uncertainty will be recognised in the community, alongside our skills in touching their bodies. This leads me onto the next topic.

Touching bodies

Examining the patient is a crucial skill to the GP. We arrange our desks, chairs and bed so we can examine the part of the body the patient wishes us to examine in the most efficient way possible. Almost all GPs will have a curtain around the bed and a door that can be closed. Examinations are private. We are good at examinations but we are so private that no one knows it. I argue that we should examine patients, we should cherish the skill and we should research it.

The medical schools do not know the value at our disposal. The recent health reforms have made staying in a New Zealand hospital bed a very efficient activity. Patients are not lying around in beds as long as they were when I was a student. So we find medical students today who get very little experience in examining bodies. GPs are an untapped resource for teaching examination skills. Surely we should let more and more students into our consulting rooms to examine patients?

Our examination skills are also largely invisible in the research world. Research into the techniques used to examine the human body is usually done in a specialist centre.

This has been a logical extension of the fact technology provides the gold standard against which we measure the value of many examination techniques. In fact GPs in the community carry out different sorts of examinations which have a different value because they see a lot of illness in the early phase of disease.

Another GP and I did an experiment where we examined the chests of about 300 children for wheezy breathing. We were blind to each other's findings and could only reach a moderate level of agreement on the presence or absence of wheezy breathing on auscultation.[2] We should be curious about such research. It's our job in the community to find out. No one else is doing it.

Appropriate behaviour

Patients just do not know about our examination skills. I am sure many GPs have seen patients who have brought their illness far too late for treatment. Many probably believed we did not want to examine their bodies. I have met a male patient who had severe anal problems for two years. He did not come to see me

because he thought GPs did not examine the anus. We may value the art of physical examination, but it does not follow that our patients know we practise such an art.

We are very quiet about one aspect of the examination. I am referring to the relationship between intimacy and touch. If you have a lover or a child in your life, one of the first things you want to do is touch them. Touch strengthens intimacy. There are cultures where touch is kept to a minimum, whereas in cultures such as my own, people seem to be all over each other.

As GPs we use touch to develop the kind of doctor/patient relationships appropriate for our culture.

We are all repelled by the doctor who sexually interferes with a patient's body because that doctor is violating an intimacy we all cherish.

Other kinds of touching are valued. The patient presenting with a lump in the armpit wants you to feel it so you know what it is like.

How you manage the fact the patient is sweating, and how gently we touch a very tender lump, will tell the patient a lot about how we deal with their sensitivities. How we deal with the clinical examination and intimacy is a crucial skill. We will not know much about it unless we talk about it. This leads me onto my next topic.

Conversation with patients

As GPs we are fortunate that we talk to many people. We close our surgery doors and chat about anything. Each of us (on average) has three to four conversations with about 1200 patients a year. We stay in our surgeries having these conversations for about 13 years (on average).1 This is a crucial skill for patients. Patients seek out the kind of GP with whom they can converse.

Patient satisfaction surveys constantly reveal that patients value the ability to talk to their GP. We do not celebrate conversation as much as we should. This bias reflects an attitude in our western culture. There is a lot said about sex, food and exercise, but almost nothing is said about the art of conversation.

Good conversations have certain characteristics. Firstly, people need to meet face to face. This allows for the exchange of both verbal and non-verbal ideas. Next, people who meet need to feel free to roam in any direction with their conversation. Finally, the best conversations are those that change the participants in some significant way. The best conversations in general practice do this.

Many GPs will tell stories about conversations with patients that changed the way patients lived their lives. Conversations also change GPs. Think of all those novel or dramatic consultations where you were left speechless. Conversations mark out a territory where we like to travel.

Violence consultations

Despite our success, it is illuminating to look at areas where we are not having conversations. I have one example from my research where I looked at how people present violence to GPs.[3] I did the research because no one had asked New Zealand GPs about the violence they encountered in their patients. We were able to estimate that GPs see about 3000 violence consultations a year. Most remain unreported.

I am interested in violence and why it goes unreported. I come from a culture that used to be called Yugoslav and now has violently fragmented. Much of their violence has gone unreported. The war in former Yugoslavia shows what happens when you first ridicule, and then try to suppress, a small subgroup of a culture.

In the 1980s I visited former Yugoslavia and was struck by the numerous jokes made about people from Bosnia and Kosovo. The jokes reflected a negative view of their lifestyle. The image was one of a superstitious, ignorant, peasant group of people who had a tendency to violence.

I remember a story which at the time was told as a joke – about an old peasant man from Bosnia who was found to be hiding a tank in his garage. He stole it from the Germans at the end of World War II. This tank was well oiled, had a complement of bombs and was ready for action. The military men took his tank away and he was heard to lament "you never know when a tank can come in handy". Clearly, we now know that old man was right.

If we listened to the old man's story about why he needed a tank in his garage to feel safe, then perhaps today we would know the reasons why people did not survive the violence in former Yugoslavia.

It was fascinating to find some GPs were very reluctant to talk about violence with their patients. The reasons for not conversing were revealing. Some GPs felt raising the topic meant they addressed issues they could never manage. Others were afraid for their own safety.

The violent male sitting in the consulting room with the abused woman does not induce a GP to talk about violence. So some of us may not be having important conversations with violent men. I am sure there are other areas of conversational neglect in our work. The problem with this neglect is that it does not allow patients to be free to choose an alternative route. Perhaps a conversation with a GP will stop a violent man beating his wife next week.

A rare freedom

In order to survive we need information management, touch and conversation – and the greatest of these is conversation. If we survive, then what? That is our choice. GPs are remarkably free even though we are a small minority of 3000 New Zealanders.

How might GPs use their freedom?

- obey a law or creed
- negotiate deals
- cultivate a private garden to shut out the world
- search for knowledge
- talk incessantly about one's feelings
- be creative

We have been largely left alone to sort out how we manage patient information, how we examine patients and how we converse with patients. We get paid for this honour. Such freedom is rare to find in other businesses or professions. We should cherish our freedom because our survival depends on knowing what to do with our freedom. A free individual is one who not only has freedom, but who knows what to do with their freedom.

What are the options open to us? The box shows a list I adapted from Theodore Zeldin when he wrote about how people choose a way of life when exercising their freedom.[4] Each item on the list is one choice GPs might make when living the kind of life they choose. All of us could brainstorm ideas on how GPs fit with each item.

Here are some of my ideas.

Making choices

The first item about obeying makes me think of the GP seeming to be a slave to the profit motive, or to religion, or to an altruistic goal of being the best of the best in general practice. The second item about negotiating deals makes me think of the GP loving to deal with complex patient problems, or the GP managing staff to make a practice buzz with activity or the GP negotiating with IPAs.

The third item about a private garden makes me think of all the places GPs buy to get away from it all, or the medical centre where everyone thinks they are best in the world – yet from the outside they appear rather self-contained. The fourth item about knowledge makes me think of the 35 academic GPs in New Zealand who seek knowledge about general practice just for the fun of it.

The fifth item about incessant talking makes me think of the GP who dominates peer review groups or the stressed GP in a practice meeting who is not coping but chooses to overwork. The final item about being creative makes me think of the GP who creatively arranges patients with incurable problems to meet each other, or the GP who creatively incorporates their childcare needs into the business plan of the practice, etc.

I am sure we could spend quite an interesting session discussing how all of us spend our freedom. Notice how conversation is central to all the items on this list. Just as we might spend hours talking about food, wine, sex or politics, I suggest we should spend hours talking about what we want to do with our freedom. In practice, this means we need to develop the art of conversation. Some of us will be influenced by such conversations to such a degree that our work will change. If this occurs, we will see an increase in the fragmentation of general practice.

Voicing concerns

I started my story by mentioning a concern many GPs have about their survival. I recognise the fragmentation of general practice in the same way as I recognise the fragmentation of ethnic minorities arising from my culture. I believe if we talk about our fears and concerns, then they will disappear or at least become manageable. I spoke earlier about the old man and his tank. No one had a conversation about his fears and concerns – no conversation, no survival.

We should celebrate our freedom. General practice will survive when we are free to have conversations letting everyone know that we are good at manipulating information, good at examining bodies and good at conversation. GPs will survive when they become passionate about the kind of freedom they have chosen.

References

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