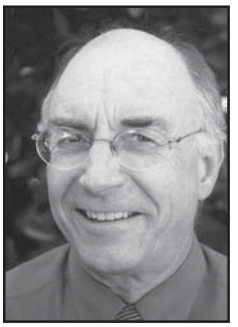
Editorial



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Reflections of a general practitioner on general practice

I have chosen to preface this talk with a song from a woman who describes the album from which this excerpt is taken as a gift – *'a taonga that allows many people to come together...these words of the past intertwining with the lives, hopes and aspirations of the listener'*. Whirimako Black, who sings *Stormy Weather*, *Marangai*, in Te Reo, says that she found a true understanding from having translated and reflected on what the writer and the singers of the songs on her album were trying to achieve. She chose lyrics to reflect this and used 'poetic licence' to add her Maori philosophy spin on it. On the album cover she adds, *'So forgive me, if it nudges you'*.

You will be pleased to hear that it is not my intention to sing the blues to you, but rather to reflect on the making of a general practitioner – this general practitioner – and to describe what I see as the future for general practice. So forgive me, if it nudges you.

I lived most of my life in Rotorua, where my father was a GP for about 40 years. I found out after he retired that he was known by some of the community as the 'father of Ngapuna' – not because he had sired most of the children that lived there, but because he had delivered them. I have no doubt that he inspired me to become a GP, as I cannot remember at any time wanting to do anything else. I learned from him about caring and I also learned that there was no clear distinction between professional life and family life. They somehow blended into each other. My mother recently reminded me of a time when my father was a young GP with four young children. A woman phoned one evening at about dinner time when my father was inevitably out doing house calls. She was having problems with her babies and, living in a small town, knew that my mother also had a young family. So she asked her for advice. This happened on two or three occasions and then, one evening, she phoned when my father answered the phone. She was taken aback and said, *'So sorry doctor, I wonder if I could speak to Mrs Townsend?'*

I became a doctor and learned about general practice from working as a house surgeon at Rotorua Hospital, doing locums for experienced GPs and spending time in some isolated rural areas. There was a lot to learn, mostly about the skills of communicating, examining, evaluating and observing over a period of time. I learned that the scope of general practice was difficult to define, because it was primarily defined by what my patients brought to the consultation. The medical hierarchy was mostly concerned with my limitations rather than with my potential. I made mistakes, fortunately not big ones. I did not have the benefit of an experienced, professional teacher to guide me, but I learned.

I started my own practice in 1974 and my GP and specialist colleagues were generous with their freely given and mostly wise advice. In the 20 years that I practised in Rotorua I learned about continuity of care and the special relationship that develops with patients over time. I became aware that sometimes my gender and sometimes my role was irrelevant. I recall on several occasions women saying to me *'but you know what it's like when you are getting your period'* and I clearly remember the middle-aged Catholic woman who, while describing the problems that she was having in her relationship, said *'but Father, he is really a good man'*. I learned about the importance of families, including my own, and that my professional interests were, to a certain extent, influenced by what was happening in my personal life. When I was having children I developed a spe-

cial interest in obstetrics and family planning, when my children were at school I learned how to teach, when my children had left home I became more interested in population care and chronic illness. I now help to look after patients in a rest home. I was particularly proud of our six children when most of them joined Merian and me at the College Conference in Christchurch in 1990 to talk about their experiences of living in a blended family that they had been part of for the previous seven years.

I read a lot about medicine and about general practice. I still have original copies of most of the papers that have strongly influenced the way in which I practise. George Engel's *'The need for a new medical model: A challenge for biomedicine'* published in *Science* in 1977; Lynn Carmichael's *'A different way of doctoring'* in *Family Medicine* in 1985; Gayle Stephen's *'Family medicine as counterculture'* in *Family Medicine* in 1989; Ian McWhinney's *'The importance of being different'* in the *British Journal of General Practice* in 1996 and Joel Merenstein's *'Patient-physician relationship, III'* in *Family Practice* in 1991 are among those that stand out, but there are many others. Then there are the books by Ian McWhinney, John Murtagh, Moira Stewart, Kerr White, Arthur Kleinman, Howard Brody and Foss & Rothenberg and, again, many more. We have a tradition and we have a discipline.

Two years ago I managed to get to a conference that was held on the Island of Kos, the birthplace of Hippocrates. I felt that I had found my roots.

But, what is the point of this egocentrism? Of course, it is not about me; rather it is about our profession. In the course of this brief reflection I have outlined the principles that make us different. We are caring and compassionate doctors who are usually the first point of contact that a patient has with the often frightening sub-culture of medicine. We understand comprehensively, we grow up with our patients and they do with us. We are trusted confidants. We are available; we have blurred the boundaries between family life and professional life and we have special skills and powerful knowledge. We are GPs; but we are endangered. Michael, my partner in practice, who is of my generation although several years younger, refers to us as dinosaurs.

The work that we do has become increasingly fragmented. Most of us no longer practice obstetrics, male GPs do less gynaecology, many of us see less acute trauma and we seldom visit patients in their own homes. Primary care specialties have developed in musculoskeletal medicine, sports medicine, sexual health, appearance medicine, youth health, occupational medicine and accident and emergency medical practice. Primary care nurses, including midwives, practice nurses and nurse practitioners have become increasingly skilled and more autonomous. Complementary care providers have become increasingly popular. Often, those of us in primary care do not communicate well with each other, even though one patient may have several primary care providers.

Neither do we communicate well with secondary care. There have been several recent examples of this lapse leading to disastrous outcomes for patients. Not only is communication poor between secondary and primary care, but access also continues to be a problem. Some often disabling conditions, such as unilateral cataracts, hernias, ganglia and varicose veins, are deemed no longer appropriate for publicly funded treatment. Most of us can cite examples of urgent referrals waiting for more than six weeks and those classed, sometimes seemingly arbitrarily, as non-urgent for more than a year from referral to treatment. A recent letter sent to me about a woman with a painful foot problem who had been bumped off the waiting list stated, *'She came off the waiting list because she had waited on it'.* Management sometimes tells us that longer waiting times make no difference to outcomes, but our patients don't believe that. This problem has not been created by doctors, but is one example of how government decisions impact on clinical practice. In the United States, government interference with clinical practice has prompted Jeffrey Drazen, an editor of the *New England Journal of Medicine* to state that: *'It is not that physicians do not want oversight and open discussion of delicate matters but, rather, that we want these discussions to occur among informed and knowledgeable people who are acting in the best interests of a specific patient. Government regulation has no place in this process*."[1] We need to beware.

There are also access difficulties in primary care. With changes to practice arrangements such as shared care, shift work, the deputation of after hours care and the increasing use of locums, patients often find it difficult to see their own doctor for acute care. We have embraced the concept of distributive injustice by allowing a situation to develop whereby patients of the same age and socio-economic status, with the same medical problems, are charged vastly different amounts for their medical care based solely on geographical or pseudo-geographical criteria.

Rural practices continue to be understaffed and their value has been eroded to a degree that renders many of them worthless. This has a knock-on effect for urban practices and amalgamation into larger, more cost-effective, groups seems inevitable. Doctors have often been criticised for being poor business people and younger practitioners appear to have taken note of this. Many are reluctant to get into ownership and management of medical practices and seem to be content to work as salaried employees. General practice super-chains are replacing owner-operated corner dairy clinics. We need to remain aware that, although concerns about Kentucky Fried medicine were being voiced in the United States in the early 1980s, this has not thwarted the development of Minute

Clinics, in which *'board-certified practitioners are trained to diagnose and treat common family illnesses, such as strep throat, bronchitis and ear, eye and sinus infections; no appointment necessary, open seven days'.*[2]

Concerns about efficiency, effectiveness and value for money spawned the concept of managed care in the United States in the early 1970s and this has now become a widespread reality that has impacted on medical practice in New Zealand. Our response to this has led to the development of less threatening practice improvement activities such as quality plans, best practice activities and accreditation.

With increasing government funding of primary care we are becoming more accountable to our stakeholders such as the PHOs, DHBs, Pharmac, the National Cervical Screening Programme and ACC, and our patients, who once seemed to be those to whom we were primarily accountable, sometimes seem to be in the back seat. Personal privacy, although maintained in principle, is being breached in practice as the protectors of the public purse access our patients' records to ensure that we are toeing the line. This, not surprisingly, invites me to reflect on the management of our health care services. I will be brief, as you already know about this, but how can we justify, for a *country* of only four million people – when there are 84 *cities* in the world with a larger population than this – 21 DHBs and 81 PHOs? New South Wales, for example, has recently reduced its 17 Area Health Services to eight, four metropolitan and four rural, for a population of 6.8 million![3]

There is more to say, but I need to move on. What, then, is the future for our profession?

Not surprisingly, I do not have all of the answers but, again, not surprisingly, I have some ideas. I would like to take you back to the beginning of this talk; to the singing of the blues in Te Reo – a break with tradition, a blending of cultures, a nudge to the conservatives.

In order for general practice to survive, and survive it will, we need to remind ourselves of the principles that have shaped our discipline. Personal, primary, comprehensive, accessible care that is concerned with the prevention of dis-ease, the promotion of health and the ongoing care of people's illnesses. Despite sometimes being called family practitioners and despite being encouraged to concern ourselves with the health care of our practice populations, we are, primarily, personal carers. Although we incorporate family functioning and population health into our practice, we are neither family therapists nor community medicine specialists. I am your doctor and you are my patient.

Although general practice will survive, the general practitioner that I have described will not. The evolution is in progress. Unlike revolutions or impositions that result in destabilising systems, changes that enhance growth while supporting stability and self-organisation are subtle. It is often only when we look back that we realise how much has changed.

As I type my case notes with two fingers, which, to my students and younger patients, is like having 'endangered species' tattooed on my brow, I reflect that although computerisation has helped communication between doctors and other health providers, we still have a long way to go. Our software systems are unable to talk to each other so we still rely on letters and faxes. Computers help us access information, evidence and protocols but there is much to be done. The recently announced *qi4gp* project is a major step in the right direction and deserves the support of all of us who are committed to high quality general practice.[4] The technology to plug ultrasound, doppler or echo into our desktop computers, as we do now with ECGs and spirometry, cannot be too far away.

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Patient-centred consulting is well established, but the focus is changing. It is now common for patients to come to us having already searched the Internet and armed themselves with information and mis-information. Their self-diagnosis may or may not be correct and their proposed management may or may not be evidence-based. Our role is to help them to critically review their data and to use our clinical skills to determine whether or not they are on the right track. This sometimes means discussing conditions about which we know very little, or sometimes discussing conditions about which very little is known. Requests for treatment unavailable in this country are now quite common. Some of these have validity. A patient who has moderate anaemia from myelodysplasia recently asked me if I could get him erythropoietin treatment as he had heard that this was beneficial. It might be, but I can't get it and nor can anyone else in New Zealand, and the reasons are not simply to do with clinical appropriateness.

Tools to help us guide our patients through the complexities of cybermedicine are emerging but need further development as both the coverage and accuracy of medical information on health websites is poor, with one large study revealing adequate coverage on only about half the sites and only 84% of what was covered being completely correct.[5] It has been suggested that this lack of information and the presence of inaccurate information will lead to cyber-malpractice.[6] Nicolas Terry, Professor of Law at St Louis University has said that with such a significant shift in medicine and the relationship between patient, doctor and pharmacist, the *'old rules don't make sense any more and the new roles haven't been defined yet.'*[3]

General practice teams are an integral part of general practice, but the models for multi-disciplinary teamwork in the Primary Health Or-

ganisation environment are yet to be fully developed. Infrastructural, employment models and contractual issues need to be addressed.[7] The role of the generalist practice nurse is expanding and their professional status is at last becoming recognised. Practice nurses will increasingly become the health practitioner of first contact and this role will extend to out of hours calls. It is likely that more doctors will job share and work shifts in order to free up their personal and family time and that the boundaries between what is work and what is not work will become much more clearly defined. What was a vocation for my father's generation and a career for my peers has become a job for Generation X.

Aside from those overseas trained graduates who now comprise 37% of New Zealand general practitioners,[8] our new general practitioner workforce will come from Generation Y. We need to be clearly cognizant of these generation differences for they will impact on general practice just as they will on the workforce as a whole. For those of us who are the dinosaurs of the baby boomer years, our work ethic was driven; for many current general practitioners, who belong to Generation X, their work ethic is balanced, whereas for those of Generation Y – the oldest of whom are now aged 27 – the work ethic is to achieve and to be flexible.[9]

Primary care medicine is not going to change markedly in the next 20 years, so how will the work of the GP be different? I agree with Peter Tate, another dinosaur, who recently retired as Convenor of the Panel of Examiners for the RCGP. He has written an entertaining and insightful series of monographs now published as *The Other Side of Medicine*.[10] He believes that the modern GP will have to be an expert consulter. This consulter will *'at the start seek to find out what it is that matters to the patient, and this requires respect and communicative expertise. Clinical competence is an absolute necessity, as is a highly developed sense of pattern recognition. The ability to synthesise the clinical necessities with the communicative imperative to achieve a shared understanding and shared management plan will be well developed. The consulter will be able to deal with a wide range of challenges, be able to cope with the ever-present uncertainty and to respond to their intuition, yet remain focused and appropriate in the use of resources, which includes the use of time. Throughout this immensely skilful process our consulter must remain the patient's advocate'*. He goes on to say that we must denigrate the purely checklist techniques that squeeze both the effectiveness and the humanity out of our surgeries.

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All of this has implications for teaching. The new general practitioners will think in systems. We will not have to teach them this, any more than we will have to teach them how to use a computer. Generation Y students are more inclined to be comfortable with a nonlinear and nonsequential mode of perceiving, thinking and investigating. They show a preference for the use of elaboration strategies to help build meaning by constructing relationships within the material to be learnt or between their prior knowledge and experience and new materials. Their expectation is that their learning is a responsibility of the teacher and not of the student. Memorising is an anathema and pictures and images are more useful for communication than the written word. Generation Y students show a preference for self-paced learning and customised products and experiences. They grew up with the experience of being the 'absolute ruler of their own digital universe,' and as part of the 'mass customisation' movement, want an infinitely personalised universe. They are receptive to self-directed learning that builds from prior knowledge to future goals.[11]

Now that is a real challenge.

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