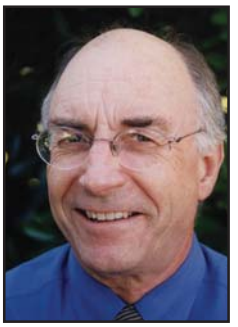
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Generalism

'I know a little bit
About a lot of things
But I don't know enough about you'
Peggy Lee 1946

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My guess is that all of us in general practice have experienced, at some time or other, the situation that Peggy Lee sang about. The uncertainty that this engenders leads us to refer to our specialist colleagues who know an awful lot about very little. The fact that we have referred somebody because we do not know enough has, in the past, reinforced a certain superiority in some of our specialist colleagues and encouraged the development of a perceived hierarchy, with brain surgeons pretty well at the top and GPs pretty well at the bottom. I clearly recall, at my public farewell from my MOSS position at a small rural hospital, which I was leaving to pursue my career in general practice, the surgeon-superintendent saying, *'we wish you well but believe that you could do much better than becoming just a GP'*. Thirty-four years later I am happy to say that he was wrong. I could have done differently, but I could not have done better.

More recently I have heard, from those at the lower end of the medical hierarchy, attempts to deflate this superiority by referring to those at the top as 'partialists' or 'reductionists'. I will illustrate these issues with a couple of examples.

The first is taken from Cecil Helman's, *Suburban Shaman*[1] an excellent book that is all about generalism by an 'old-fashioned' GP. The author enjoys attending weekly grand rounds at the local hospital. He says that he actually likes the 'hard science' of medicine that these presentations reveal. *'In the face of suffering, science is a comforting worldview.'* However, he goes on to write:

'But in this particular hospital, the weekly display of medical hierarchy often goes together with a certain ritual, but polite, humiliation of 'the GP'. This mythological figure appears as a minor character in several of the case presentations: as a figure of fun, the Joker in the pack, the bumbling, well-meaning generalist with supposedly limited skills ('The GP, of course, thought it was only a cold', 'I'm afraid the GP just gave him some cough medicine, and sent him home', 'The GP only referred him to us when it was already much too late'). Many of the Consultants in this hall seem to see the local GPs as honest craftsmen and artisans: decent, well-meaning folk, but not 'real' gentlemen – or 'real' medical scientists – like themselves.'

The second illustration is from Kevin Grumbach writing in the *Annals of Family Medicine*:[2]

'It is said when students enter medical school, they care about the whole person, and by the time they graduate, all they care about is the hole in the person. Current medical education inculcates many of the dominant values of modern medicine: reductionism, specialization, mechanistic models of disease, and faith in a definitive cure.'

Both of these perceptions contain a kernel of truth, but they also detract from the reality of holistic health care. We are all important and we all have particular and essential roles to play in the care of our patients' health. If we think about this from a systems perspective, we can see that our role, and by 'our' I mean primary care generalists, primary care specialists, specialist generalists and secondary and tertiary care super specialists, is to help patients to remain in a dynamic but stable state of health by providing both positive and negative feedback until, at some stage, we are no longer able to do this when we then continue to provide care as their systems destabilise.

Generalism is threatened. These threats are more apparent in the United States than in those countries, such as New Zealand, that have retained a strong primary care general practice philosophy, but they are still there. Gordon Moore and Jonathan Showstack comment on what they regard as a primary care crisis. They write:[3]

'Ironically, in the current health care quagmire, patients' desires for a physician who is accessible and an advocate and coordinator of their care highlight the potential importance of primary care while at the same time making primary care's

'failure' all the more disappointing and apparent to patients. Primary care now faces additional challenges, some of which may threaten its very existence. These threats include increasing fragmentation, growing competition, changing consumer preferences, the advent of 'population' models of care, adverse changes in payment systems, the emergence of new primary care subspecialties such as hospitalists, and new paradigms for health care delivery.'

If we are to minimise these threats we must emphasise those components of generalism that are important, that promote healing and reduce suffering. Glen Colquhoun, author, poet and GP on the Kapiti Coast has written the introduction to Cecil Helman's book. He describes his experiences with the first patient that he looked after as a junior doctor, a Mrs H.

'When I think of Mrs H now I remember the medicine doctors usually learn before they learn to be doctors: humour, instinct, touching, faith. So often these seem a vital adjunct to more traditional treatments. Medical schools can sometimes bury them beneath a pile of information. Patients usually have to find doctors somewhere underneath this debris before we can be useful to them. Ten years later I think the art of medicine is probably the art of balancing the considerable technical tools we possess as a profession with the equally powerful capacity we have to listen and care and laugh and touch.' He then goes on to say that, *'Before reading* [Helman's book] *I didn't know what I was doing when I held a patient's hand or made them laugh, when I prayed with them or gave them a pill I knew would work even though there was no evidence that it should. Thanks to Cecil Helman I know now I am being a witch-doctor. It is a resource that has got me through some difficult cases. It was medical school that turned me into a doctor but Mrs H made me a shaman. After her I couldn't believe any more in a medicine that contained the spirit of one but not the other. I am certainly a proud inheritor of the predictive power of western empiricism. It is stunning and beautiful in its own right. But I am also very glad to be a shaman, an interpreter and interrupter of stories.*'[1] A true generalist.

The theme of this issue is generalism. Not because it is better or less or more important than specialism but because it is what most of us do. We need to understand what it is, be good at it and be proud of it.

References

1. Helman C. Suburban shaman. Wellington: Steele Roberts Publishers; 2007.
2. Grumbach K. Chronic illness, comorbidities, and the need for medical generalism. Ann Fam Med 2003; 1:4-7.
3. Moore G, Showstack J. Primary care medicine in crisis: toward reconstruction and renewal. Ann Int Med 2003; 138:244-247.