New horizons, old values

Remaking the reputation of generalism in a changed world

Campbell Murdoch MD PhD FRCGP FRNZCGP FRACGP

Come gather 'round people
Wherever you roam
And admit that the waters
Around you have grown
And accept it that soon
You'll be drenched to the bone.
If your time to you
Is worth savin'
Then you better start swimmin'
Or you'll sink like a stone
For the times they are a-changin'.[1]

*

***Campbell Murdoch** is Head of the School of Primary, Aboriginal and Rural Health Care at the University of Western Australia. He has also been Professor of Rural and Remote Medicine and Head of the Rural Clinical School, based in Kalgoorlie, since 2002. From 1999 to 2002 he was in rural general practice in Winton, Southland, and also was Editor of NZFP. Originally from Scotland, Campbell came to Dunedin in 1983 to head up New Zealand's first Department of General Practice. Since then he has chaired Departments in the UAE and Malaysia. His main research interests have been in person-centred care of people with intellectual disabilities and chronic fatigue syndrome.*

It seems only yesterday (1968) that I started my first partnership in general practice and became fascinated by a special world where things are not quite what they seem. Having been encouraged to try to make sense of this world through research and teaching, I then became a Senior Lecturer in General Practice in 1976 in Dundee. These were exciting times in a new discipline. The first independent Department had opened in 1963 in Edinburgh with Richard Scott as the first Professor. Jimmy Knox was appointed to Dundee in 1970 and my task, as his first Senior Lecturer, was to develop a teaching practice. In 1983 I came to the Edinburgh of the South to set up New Zealand's first independent Department of General Practice as the country's first Elaine Gurr Professor.

General practice in New Zealand has the finest values in the world... We have a lot to be proud of – a patient-centred, team-oriented and humanitarian approach

Two threats and a promise

In those far off days we believed, naively as it turned out, that general practice was the foundation of the NZ health system and that the solution to our problems was simply to bring the GMS benefit in line with inflation. We waited and waited and it did not happen. I remember meetings with Eric Elder who surprised us all by his very different approach to the discipline. Eric was never much interested in money; he used to declare that it was all right to give second opinions but that you shouldn't charge the patient: he never sent out bills unless he was going on a sabbatical. In his 1978 College Oration[2] he recognised two threats and a promise. The first threat was that of rising costs and the difficulties that these would create. His solution to the rising cost of prescriptions was a novel one: the doctor should pay a proportion of the cost of each prescription – professional integrity nicely balanced against self-interest. The second threat was that of *'piles of certificates'*; all this thirty years before our red tape issues. The promise was *'the impending increase in teaching in general practice'*. It is interesting to reflect that the threats are now a reality and that the promise has been an empty one, largely because we have failed to promote the truly unique features of our discipline.

The evidence is that times have changed, but just how much is clearly seen by reading that oration. To Elder, the general practitioner was not some clerkish gatekeeper to the health system; he (and it was 'he' to Eric – sorry) was the health system. The GP was surgeon and obstetrician and Elder's voice

thunders out of these pages as it did when he chaired meetings, towering behind terrified young specialists and laying down the law:

'The high place which the family doctor holds in public regard in New Zealand has been a subject of comment from time to time. Not everyone has been always happy about it. However modest [sic] *be our inclinations, we should not tolerate any unwarranted attack on our practices and methods, or any lack of reasonable respect for our standards.'*

Somewhere along the road from then to here, something went sadly wrong, along the lines of the threats and not just from the Health Department, the convenient bête noire of the 70s and 80s. Costs have sky rocketed and tax funded District Health Boards built up deficits while private general practice went to the wall. The 'pile of certificates' became a suffocating certification exercise and the organisations that we fund, such as the Medical Council, the College and IPAs are often our worst enemies in this respect. Another great prophet, Gayle Stephens,[3] writing in 1982 described how we would become:

'Over the years we have tended to become a much more formal organisation, accepting a political responsibility to represent our discipline in the medical bureaucracy and struggling for funds. We have imposed restraint on members' participation in meetings; now there are committees which determine who may speak or make presentations, and our activities are increasingly delegated to a paid professional staff. We have evolved an orthodoxy of beliefs and practices by which we judge others and outsiders. In short, we are fast becoming a church.'

The news from Australia is the same as from New Zealand although here the church has split between rural medicine and general practice. Proceduralists are overpaid and generalists such as general physicians, paediatricians, surgeons, geriatricians, psychiatrists and GPs are underpaid. GP numbers are declining and GPs are ageing. Even where GPs are still desired, increasingly workforce requirements are being met by overseas-trained doctors. Rural areas are the worst affected. The current political 'fix' in Australia for these problems is to vastly increase the numbers of new doctors (more cost) by opening five new Medical Schools. In Western Australia we will have one of these and, by 2012, the numbers of graduates will double. All this is on top of a rapidly increasing medical workforce, up 13% from 1996 to 2002, but struggling because all doctors work less so that the end result is a decrease in full-time equivalents who work 45 hours a week from 278 to 271 per 100 000 of the population.

The vital need of a sensible generalist

So where does all this leave the art of general practice? General practice in New Zealand has the finest values in the world and I feel very proud of the privilege of being part of its academic development. We have a lot to be proud of – a patient-centred, team-oriented and humanitarian approach, which I saw at first hand when I practised the art in Mornington and Winton. General practice in New Zealand is a class act by world standards. The vast majority of patients are also convinced and their only complaint is that they can't get enough of what we have to deliver. Even 18-year-olds in New Zealand were highly satisfied by GPs.[4] A recent study in Australia has reiterated what we all know: that in rural NSW the professional most valued is the GP – 'by a country mile'.[5]

A recent study in Australia has reiterated what we all know: that in rural NSW the professional most valued is the GP – 'by a country mile'

My thesis is that much of our decline is the result of what Elder described – *'unwarranted attacks on our practices and methods and lack of reasonable respect for our standards'*. In some ways our problem is that we have offered a too highly skilled and complex service. In Winton, after a very complex consultation I dreamily reflected on a potential research study called the DEVOID study. The selection criteria were:

***D**epressed Housewife with an*
***E**rrant Husband,*
***V**aginal Discharge and a*
***O**ne-year-old child with*
***I**nsulin Dependent Diabetes Mellitus, who*
***D**oesn't usually attend this practice.*

Real, but too complicated? Perhaps, but just one fifteen-minute interlude in the day of the average family doctor. It was a very complex consultation involving psychiatry, marriage guidance, sexual health, paediatrics, and endocrinology. In no other branch of medicine could she just walk in and expect the doctor to deal with all her problems. Our specialist colleagues could only solve bits of it, she needed a GP to look after her and them. As a master of my discipline I was very happy to walk across the thin ice and retrieve her from her plight. I learned in my role as a 'national expert' in ME/Chronic Fatigue Syndrome how easy it was to bring comfort and healing to individuals and families even in the midst of uncertainty and ignorance.[6] The good GP walks on the 'edge of chaos' all the time and refusal to take this responsibility is one of the root causes of the explosion in health care costs. Innes et al.,[7] in a recent review of complexity in general practice have made this point:

'For too long the medical process has been presented as one based on predictability and certainty, a presentation supported by the myth of physician supremacy and the power of modern medicine. Both patients and doctors have, at times, taken too much comfort from the predictability and certainty with which they want to endow medicine. The 'necessary falli-

bility' that arises from the complexity of individuals and health has been largely ignored. This places an unrealistic and unfair pressure on the doctor to find successful solutions to all problems and denies patients the opportunity to share and understand the uncertain reality of illness and health care. Doctors need to work with uncertainty and unpredictability in ways that is both creative and relatively safe.'

General practitioners have caught a disease that I call 'painting by numbers'. Numbers such as age, BMI, blood pressure and laboratory results dominate our thinking. The pressure to find successful solutions to all problems drives our patients to the specialists, the labs and the radiology suites and then we are all surprised that it is all costing a bit much. A recent example is the tendency for people with a 'little bit of dizziness' to be sent 600km from Kalgoorlie for an MRI scan, when what should be done is the exercise of sitting them down, giving them a reasonable explanation and using time as a diagnostic tool, remembering always to give them some way of referring back. The health system is rapidly disappearing down the drain of extravagant proceduralism and the outlook is grim unless the disease can be stopped.

General practitioners have caught a disease that I call 'painting by numbers'. Numbers such as age, BMI, blood pressure and laboratory results dominate our thinking

My thesis is that the health system is in dire need of a breed of sensible generalists; professionals who are expert in the persons and the communities which they serve, supported by at least a majority of the community who value their opinion. This is not just about doctors but practice nurses, receptionists, paramedics and ambulance officers, care attendants, pharmacists and all the carers who make up the local team. But this team needs leadership and the obvious leader is the general practitioner.

The promise and the underpinning safeguards

The promise that Elder could see was the impending increase in teaching in general practice. I recall that he regarded me, with others, as the bearer of that promise – it is always humbling to be aware of the respect of the awesomely gifted. In many ways I feel I have let him down. There now have been eight Professors and six Associate Professors of General Practice, but has there been a fourteen-fold benefit to the discipline? Having been promoted from a Chair of General Practice to being a full-time rural general practitioner and now to a Chair of Rural and Remote Medicine, I sometimes wonder. Apart from the first incumbent, whom the Otago Daily Times described as *'a maverick going to greener pastures'*, we have gained a lot of respect from academia, governments and the medical establishment, but was that really the point? When Pippa Mackay retired as Chairman of the NZMA she made the point that if general practice did not exist, it would have to be invented. We exist and do not need invention; what we need is promotion through the promise of teaching.

There are three essential pillars of preparation for clinical general practice and these are:

1. The Person-centred Clinical Method[8]
2. Clinical Decision-making
3. Clinical Wisdom

Teaching in general practice, in my view, has been a pale imitation of what goes on in the other specialties and needs a radical review. The major problems are that the process takes far too long and that those involved in the various parts of the process don't seem to communicate. The modern undergraduate is taken to a much higher level of understanding of the discipline but this tends to be lost in the 'black hole' of the compulsory RMO runs. The New Zealand system is, however, still the best of a comparatively bad bunch as it encourages people to acquire their own practice early and provides them with a beneficial learning environment. My own successful training programme consisted of two years' internship, three weeks' vocational training and thirty-seven years' continuous learning.

The Person-centred Clinical Method

This is the essential requirement for each general practitioner. This sets the landscape against which our reputation has been and will be made. Another prophetic statement comes from Marinker:[9]

'At the centre of general practice is the encounter between the doctor and the patient. If we fail to value the uniqueness of the doctor and the patient, the role of feelings and situations in the interpretation of symptoms and findings, we are condemned to be second rate players in a second hand game.'

Clinical Decision-making

This is another area where our reputation is won or lost. Last week I was the third doctor to see a 30-year-old man with an acute abdomen. No one had done a rectal examination but he had peritonitis caused by a ruptured diverticulum. One of the unfortunate side effects of the shorter working week of the doctor is the lower throughput and resulting lack of experience – I should know; I was an academic who went back to full-time practice. The only place to practise this is in the practice, preferably with your own patients. As Elder would say, *'It is quite impossible to teach anyone to ride a bicycle by giving him exposure to an automatic-drive Mercedes.'* A recent editorial from the United States summed the problem up:

'Modern medicine – bewitched by technology, bothered by its cost, bewildered by those who need it but cannot afford it – would do well to step back, re-examine itself. We recommend a thorough check-up. Preferably by a doctor who takes the time to look, listen, even touch. This should

not be difficult to arrange. There are many such doctors out there. Good ones. For now, anyway.'[10]

Clinical Wisdom

This is the synthesis, the ultimate goal of the sensible generalist. Some years ago before an overseas trip, a friend went to his GP for 'a few Diastop' as he had a little bowel looseness. The outcome of that consultation was not some pills but a rectal examination, a rectal carcinoma and an anterior resection within a few days. He is now cancer free several years on. This combination of knowledge, skills and attitudes is a priceless asset and I don't think we yet know how to assure it. As an examiner in the FRACGP clinical examination I can see that some have it and others have not. Elder's point was *'Reading maketh a full man. Conversation maketh a ready man. In general practice you have to be ready.'*

And what of research?

The academics would always say that teaching and research are essential bedfellows, but we have a real problem with that assumption in our discipline. Indeed a recent *Lancet* editorial[11] felt that our discipline is a lost cause with respect to decent research. Ian McWhinney[12] made this point:

'Few family physicians are engaged in research and our literature has had little effect on medicine as a whole. Before regarding this as a fault, we should consider the possibility that family medicine has the balance between research and practice about right.'

Our problem is that our practice numbers are small and that our populations are so unique. However they are real, not abstracted or imagined. A wise man once said that the real purpose of research was to demonstrate that stories were about real life and situations such as the DEVOID scenario above need to be told not proved. The problem with the abstractions of research was pointed out by Elder in a humourous manner:

'Ask for an opinion and you get three other opinions – any opinion, it seems, other than their own. You ask, "Is it a fine day?" They say, "Well, Smith of Denver said it was a fine day in 1976. But Jones of Boston reported some very poor weather in 1977. On the other hand, Hammerstein in Oklahoma says 'Oh what a beautiful morning.'" It is quite hard to persuade anyone to go over to the window and have a look.'[2]

My own successful training programme consisted of two years' internship, three weeks' vocational training and thirty-seven years' continuous learning

Like most academics we have come to regard Research as an entry ticket to the honours of academia rather than as a genuine answer to the problems of general practice. It is very difficult to gain a Nobel Prize in the intricacies of the Smith Family over 20 years.

Faith is the substance of things hoped for

The old general practice is dead and gone and it would be wrong to try and dig it up, but that is far from saying that there is no future for our discipline. Our values were perhaps too closely aligned to old virtues such as private enterprise, maleness, patient-loyalty, but ultimately we failed because there were no superheroes to replace the Elders, the Carsons, the Bassetts, the Anyons who doubtless rotate vigorously in their graves. The bottom line, however, is that getting rid of us and replacing us with IPAs on the right and PHOs on the left, has not solved the basic issue. People need their own doctor and, if I were investing in the future, I'd be preparing now for the renaissance. Showstack and his colleagues[13] see a bright future for primary care, but it must be in the context of a radically reorganised health system, not the current lazy method of adding us on to a failing health model.

*

The line it is drawn
The curse it is cast
The slow one now
Will later be fast
As the present now
Will later be past
The order is
Rapidly fadin'.
And the first one now
Will later be last
For the times they are a-changin'.

References

1. Dylan R. The times they are a'changin'. Copyright (c) 1963; renewed 1991 Special Rider Music.
2. Elder EM. The College Oration 1978. NZ Family Physician 1978; 5:10–1.
3. Stephens GG. Family medicine as counterculture. Fam Med. 1989; 21:103–9.
4. Murdoch JC, Silva PA. The use of general practice services by eighteen year olds in New Zealand. NZ Med J 1996; 109:113–5.
5. Smith KB, Humphreys JS, Lenard Y, et al. Still the doctor – by a country mile! Preferences for health services in two country towns in north-west New South Wales. MJA 2004; 181:91–95.
6. Murdoch JC, Denz-Penhey H. Chronic Fatigue Syndrome: A patient-centered approach. Oxford: Radcliffe Medical Press; 2002.
7. Innes AD, Campion PD, Griffiths FE. Complex consultations and the 'edge of chaos'.
8. Stewart M, Brown JB, Weston WW, et al. Patient-centered clinical medicine – transforming the clinical method. Oxford: Radcliffe Medical Press; 2003.
9. Marinker M. Journey to the interior: the search for academic general practice. J Roy Coll Gen Pract. 1987; 37:385–8.
10. Reilly BM, Smith CA, Lucas BP. Physical examination: bewitched, bothered and bewildered. MJA 2005; 182(8):375–376.
11. Editorial. Is primary-care research a lost cause? Lancet. 2003; 361(9362):977.
12. McWhinney IR. 'An acquaintance with particulars.' Fam Med 1989; 21:296–8.
13. Medawar PW. Pluto's Republic.
14. Showstack J, Lurie N, Larson IB, et al. Primary care: the next renaissance. Ann Int Med 2003; 138:268–272.