General practice in the megazone

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Once upon a time, I sat in my surgery on an island in northern Norway. In came an old fisherman with a broken finger, and very bad hearing. At the end of the consultation, I asked if we should give him a hearing-aid. He answered: "No, I will have no hearing aid, I have heard more than enough in my lifetime." So have you! You have 'congressed' now for 3 days. You dined and wined and danced last night. Your brains are probably not fit for complex input, so let us start simply, with children's hour, on radio, some Saturdays ago.

The interactive GP

A woman reporter interviewed 4-6-year-olds about frightening things. One boy had been terrified for a month. Every evening, when he went to bed and his mother had said goodnight, a monster, which had hidden under the bed, crawled out. The boy said: "And the monster gobbled me up [a short, dramatic pause]: *Without chewing!*" This little boy had been well brought up, and told every day that he must chew his food! It was bad enough being gobbled up by a monster, but the worst thing of all, judging from the intensity in his voice, was to be eaten by a monster, who did not chew him first.

What can we learn from children's hour? That pain, fear and illness perception are sculptured by our upbringing, norms and society. That disease does not exist, only the experience of disease. That health and disease consist of amino acids and self image, cell membranes and human ideals, muscles and politics. We must memorize Immanuel Kant: "The patient is not ein Ding an sich. The GP is not ein Ding an sich, the GP is interactive." Health, disease and the patient–doctor relationship are relative phenomena, strongly influenced by trends of modernity.\(^1\)\(^2\) The clinical 'stuff' in our practices is moulded by politics, by economy, by religion, by culture. In an attempt to rejuvenate, I have named these political, economical, religious and cultural forces of modern times the 'megazone'.

What happens in the microcosm of the consultation is a reflection of what goes on in the macrocosm of society. Hopes, expectations, complaints expressed in our surgeries, echo the collective soul of modern times. But general practice is not merely a passive reflection, a dead echo of modernity. GPs do feed back to society. The body of GPs communicates with the megazone. The aggregate of doctor–patient relationships constitutes a GP body–society relationship.\(^3\) To explore this relationship, to enlighten the GP–megazone interaction, is the aim of this lecture.

The creed

What are the fundamentals of general practice that fuel our interaction with society? Here is my creed:

- I believe in personal doctoring. Continuous relationship with patients is a *conditio sine qua non* for general practice. Personal knowledge and mutual confidence enable the GP to match appropriate service with the needs of the individual patient. I believe in Sir William Osler’s aphorism that it is much more important to know what sort of a patient has a disease, than what sort of a disease a patient has.\(^4\)
• I believe in a specific GP competence, comprising generalized clinical skills adapted to the clinical probabilities and risk management specific for front line morbidity and the low technology setting.

• I believe in the GP as a master of pragmatic medicine, that is making medicine doable in the human jungle. I believe in Oster’s saying: “The man who translates the hieroglyphics of science to the plain language of healing, is certainly the more useful.”

These are the eternal values, the DNA molecules, replicating the nature of general practice from generation to generation. Those genes are manipulated by politico-economical and socio-cultural forces, and we must hunt the answer to the question: what happens when the Creed confronts European reality in 1996? Let us move now into the megazone.

Politico-economical interactions

The divided society

Galbraith has introduced the concept of the three-quarter society, where the content majority, well-educated, with good income and good health, becomes increasingly egoistic in their search for greater well-being, more comfort, more security and better health. On the other side live the losers of society: the unemployed, the poor, the disabled, ethnic minorities, often in inner-city ghettos with a high level of violence, injury and disease. The GP stands for availability. He works near society. The people need the GP as an ally in the strive for a health care based on solidarity and equity.

The commercialization of health

There is a strong worship of money in modern times. The holy market supersedes political principles, religious norms and professional standards. Neocapitalism may corrupt clinical practice. The commercial exploitation of people’s health culture is particularly obvious in two areas:

(i) in the comfort zone, where an attempt is made to redefine lack of well-being and deviation from idealized beauty as disease;
(ii) in the fear zone, where natural risks, variety in life and healthy dangers become medicalized.

The experience of the USA has shown that clinical decision making becomes influenced by private money making. In a market-orientated system money is made by a faster turn-over of patients, shift from continuous care to episodic care, increased referral rate to specialists, increased numbers of tests and increased prescription of drugs. The GP has always been the poor man in medicine. This is one of our proud traditions: we have never let money overrule the patient.

The invasion of the clinical field by bureaucrats

The drive to standardize and economize clinical care is world-wide. Keywords are: managed care, gatekeeping, fund-holding, cost-effectiveness and quality control. Patients are redefined as units of production; diagnosis and treatment are given a price; the profit of investing in treatment procedures is calculated in quality-adjusted life years. The bureaucratization of the clinical field can weaken the humanistic tradition in medicine, reduce clinical freedom and jeopardize confidence and secrecy between patients and doctors.

Colonization by bureaucrats is most advanced in hospitals: the trend is also clear in general practice, but our resistance is stronger. Every day, in our practice, we experience the uniqueness of individual patients. We observe that sameness in ICPC number is not sameness in real life. This empowers us to be medicine’s freedom fighters.

Socio-cultural interactions

The rapidity of change

Freud urged us never to forget “Das Mensch ist ein Tier”. Man is an animal, an animal of habit. To feel secure, man needs predictable structures. Modernity is characterized by rapid change. Modern times suck us out of our local habitats and expose us to a mobile world with new challenges, strange threats, fresh stress every day. The rapidity of change outstrips our capacity to adapt and cope. A health service dominated by disposable doctors, fragmented hospital care and episodic specialist visits may accelerate the rapidity of change and the feeling of alienation. The GP, who has the power of continuity, can provide sick people with stability and security.

The iron cage of rationality

Weber was the first clairvoyant philosopher to foresee another dominating modern trend: the infiltration of rationality into all aspects of life and love, with a concomitant loss of poetical qualities. Rationality has become the steering principle both in capitalist economy, in government and in modern medicine. Illich states that the picture of man is reduced to ‘Homo economicus’. He polemicizes against the spirit of time which “reduces persons born for suffering and delight to self-sustaining information loops”.

Imprisoned in the iron cage of rationality, patients and doctors may see two dangers: first, advances in science and technology give patients and healers an illusion of mastering the universe. Life can be calculated, society can be designed, danger can be overcome.
Since science is all powerful, why accept disease, suffering, injury? The other complication of science is the technological mode of response sick people meet in modern health care. It is an increasing complaint that patients are treated like bio-machines, without human touch. Once again modern times call upon the GP, who experiences 20 times during the day that disease is a bio-psycho-social construction, and who conveys realism and compassion in the doctor–patient relationship. Science devalues God, which brings us to the next symptom of modernity.

The fall of religion

Doris Day identified an effective tranquillizer in all religions when she sang: “Whatever will be, will be, quie sera, sera.” Religion brought peace to threatened humanity with the concept of destiny, which made disease and accidents tolerable. God also prescribed hope, which is not an authorized drug in the European formulary 1996. We will never be successful in medicine as long as we imagine that the patient is a rational being. Human beings are not robots, whose behaviour can be programmed. We often flirt with danger, we throw caution to the wind, we rebel against doctor’s order, and sing along with Leonard Cohen: “They sentenced me to twenty years of boredom”. We are warm-blooded, passionate, unpredictable hominids, closer to animals than to the health nurse, guided more by basic instincts than by the Commissioner of Health in Brussels. A wise health service must accept and respect the counterfactual irrationality of man.

Medico-scientific megalomania

God, destiny and hope have to a large extent withdrawn from modernity, displaced by medico-scientific megalomania. Modern technological medicine converts more and more of biological variation, natural stress, and the natural troubles of life into diagnoses with demands for specialized investigation and therapy. The result is a malignant combination of learned helplessness and perfectionist expectations among patients. There is a strong expectation for health, optimal biopower and optimal psychopower, in contemporary society: genetic engineers provide society with fault-free bodies, the education system demands healthy boys and girls who can be made fit for fight in the European jungle, employers demand effective bodies and adaptive minds, politicians prefer smoothly functioning citizens, doctors demand correct life-styles. People strive for perfect health, because health has become the one and only key to enter happiness: the key to money, love, work, entertainment, social respect, self-esteem. The modern health cult is a delusion opposing biological laws, contradicting life itself. The imperative of health produces stress, disease and extravagant demands on health care.

In modern times, the GP has to counteract healthism. The GP works close to misery and happiness, beauty and ugliness, wickedness and goodness. He understands that imperfection is the lot of man, and that a sound health culture must accept the unavoidability of pain, trouble, malfunction. The GP can advocate the human right to be imperfect.

The potential

We have discovered now that medicine does not sculpture itself in a vacuum. Diseases are not absolute biomedical standards, doctors are not absolute biomedical robots. We have observed that the theory of relativity also holds true for medicine:

\[ m = \frac{1}{c^2} \]

medicine equals biology times culture times politics squared.

So what? the tough guys will ask. Cut the cackle, let’s have some action, the hardware boys will demand. What’s in it for me? the utilitarians among you will enquire. This is the acid test of my lecture, and here are my basic answers.

Intellectual delight

Intellectual delight has a value per se. It can be counterproductive for a discipline to persecute lust thinking with cravings of immediate practical implementation. Perhaps the only outcome of this lecture is the joy of understanding, that is quantum satis, that is enough. But, perhaps there is a practical potential, too, in spotlighting general practice in the megazone. Perhaps, the GP can contribute to a sound health/illness culture. GPs do mould people’s health and illness culture by their sheer being, by their pure doing, whether or not this is done knowingly or willingly. Each of you will have 120 000–140 000 patient encounters during your professional life-time. This very year, one billion direct patient contacts will occur in European general practice. This provides the GP body with a huge amount of communication power.

Words said, silence kept, drugs given, a demarcation line drawn, an eager-to-please response, laboratory tests not taken: the accumulated stimuli of our one billion consultations shapes Europe’s health concept and forms Europe’s Illness experience. The question is not “to be or not to be a styler of patients’ health concept and illness behaviour”, the de facto choice is to be a conscious or an unconscious styler. General practice can be performed in an amoebic fashion or with a spine. Doctors can mould health culture by omission, by giving political, commercial and technological forces a free hand. Or we can use the one billion a year consultation potential actively to promote a healthy illness culture. Thereby we can bring a new social dimension to the individualistic ideology of general practice.

GPs are accused of bearing the motto: ‘Focus the patient, blur society’. The individual patient–doctor relationship is—and must be—the source of life for general
practice, but that does not mean that we need to kill the collective GP body-society relationship. To focus in research, teaching and practice on the shaping of people's medico-cultural beliefs, expectations, behaviours, may provide general practice with some of the community profile we have neglected. Perhaps our policy makers in WONCA should market our medico-cultural designing potential more aggressively.

I can read thoughts. I feel now in my telepathic receiver that many of you think: "Oh God, another God-maker, who wants us to be Gods, another imperialist who will expand medicine into politics and culture, another megalomaniac who will inflate the omnipotence of general practitioners". This is not a question of introducing something new, it is a question of bringing some light and structure and limitation to an old, inherent part of general practice, the medico-cultural shaping potential.

The strategy

To realize the medico-cultural challenge is not to go for doctors without borders. The first strategic move is to define the core content of general practice. To recognize that general practice interacts with the megazone, does not mean that the whole megazone is our business. On the contrary, may this insight bring us from catacata to vision, make us see that general practice must delimit itself from the totality of life and the totality of society. We must not allow general practice to be the dumping place for social stress and political pathology. Nor should general practice be the market place for sophisticated consumers in pursuit of perfect bodies and pain-free lives. Nor should our surgeries be confessional boxes for the perplexed, nor laboratories be for the Ulysses-like exploration of somatized unhappiness. A general practice without boundaries makes the GP a master of none, a jack of all trades.

To interact with the society in a credible and sustainable way, we must agree on a core job description for our principal role as doctors, and make that job description, especially the 'not our business' part of it, clear to our patients, managers and politicians. It is not easy for the individual colleague to say those yesses and noes in the heat of the surgery. To define the nucleus of general practice must be a collective challenge, well suited, I presume, for a WONCA Working Party. The next strategical step is to act as messengers ad modum doctor Rieux.

The first-line doctor is in a unique position to observe how political misdeeds and social injustice hurt bodies and minds. Instead of taking part in a clinical masquerade, GPs should practice early warning, act as our colleague Dr Rieux in Camus' novel, La Peste: "Doctor Rieux resolved to compile this chronicle, so that he should not be one of those who hold their peace, but should be a witness in favour of those plague-stricken people; so that some memorial of injustice and outrage done to them might endure; and to state quite simply what we learn in a time of pestilence: that there are more things to admire in men than to despise."

The third strategic approach to an improved GP-society interaction is to advocate a natural concept of health and disease. GPs should re-orientate health education from technical information to more fundamental influence on concepts, attitudes, expectations and responsibilities in the matter of health and sickness. We should engage in a new health education which provides: generous limits to normality, tolerance for biological and social variation, respect for Nature's command over human life and motivation for people to promote health and care for the sick themselves, outside the domain of medical experts.

We should promote health education: which cures people from having unrealistic expectations, confesses the ignorance of medicine and admits the uncertainty of clinical practice. Each one of us can do this in meetings with our patients, but again concerted, collective efforts are necessary. Perhaps, The National Colleges of General Practice should establish a GP fire brigade, flying out to the public to extinguish false hopes or real fright, ignited by cow-mad specialists and speculative media?

Protect autonomy versus political, economic and administrative power structures

To counterbalance political, economic and administrative deterioration of public health, GPs have to keep their distance from these power structures. 'Yes' to an independent medico-cultural designer role means 'no' to political, economical and administrative subordination. Allen Ginsberg, spiritual father of the hippie movement, proclaimed: 'turn off, tune in, drop out'. General practice cannot drop out from reality, but we ought not to tune in and harmonize too much with the Establishment either. GPs ought to have more flowers in their hair, be less obedient, more courageous. 'But we must adapt to change', sounds the refrain from flexible colleagues. To adapt to change is not a virtue in itself—it depends on the change. There are times for a person, for a profession, when it is mandatory not to adapt, but to resist and to change change. Of course, general practice cannot be an island (of love) in splendid isolation from ugly politics, dirty money, bad administration. But keeping a cool distance from political, economic and administrative power structures does not leave us alone. On the contrary, professional autonomy may link us closer to our best allies, our patients, and the powerful sum of them, the people. One hundred years ago was a glorious period for general practice in Europe, and the WONCA of that time proclaimed in a Manifesto, 'we are a body of men who exists
because the wants of the people have raised us up’. In clinical practice the GP has always been committed to the patient. In medico-political practice it may be wise to commit to the people.

The end

The Danish philosopher Piet Hein said: ‘Time is the most stupid invention of man, should be used to boil eggs only’. However, we have to approach the end, with a final appeal, paradoxically perhaps, for wrapping up a scientific congress: we have to protect general practice against science. There is now a world-wide urge for research, documentation, classification and evidence-based standards in general practice. So far, so good, but further may be bad. I see a danger in the scientific overkill of general practice, which is not and should never be a scientific discipline. The *raison d’être* for general practice is not practice, not science. The mystery of general practice derives from Iona Heath and the Aristotelian concept of ‘phronesis’. Phronesis means practical wisdom and can only be gained by personal experience. Phronesis is achieved by exposure to individual cases. It is a kind of learning by doing. Phronesis is personalized competence, an amalgamation of knowledge, instincts, feelings, experience. Phronesis can never be decoded, but it can be destroyed by science. Because, when phronesis becomes confounded with science, passion and self-reliance fly out, and cold blood and pretension flows in.

Descartes said ‘I think, therefore I am.’ Valery, who might have been a GP, said the same thing more wisely: ‘Sometimes I think, sometimes I am.’ Sometimes we are with the patient, in the consultation. We must protect those moments of pure being from the analytical attacks of science. Aristotle himself valued phronesis higher than scholastic science.

We should conclude this 3rd European WONCA Congress with a unified resolution, stating that: ‘The real thing is not Coca Cola, not academic institutions, not scientific meetings. The real thing is phronesis, practical wisdom, as operated by each one of you in your surgeries.’ Go home proud and confident, knowing that Johann Wolfgang von Goethe had you in his mind, when he proclaimed: ‘Gray, my good friend, Gray is all theory now, and Green is life’s own golden tree.’

References