Editorial

Prejudices of a Local Medical Doctor

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It has been said that the need to be needed is a prime motive in a person's decision to enter a career in medicine.[1] The choice of a specialty, however, is governed by other considerations, since the need to be needed is common to all physicians. I have been a general practice physician for almost all of my professional life, and have derived great satisfaction from the calling. In fact, the association of many years with trusting patients and their families, the excitement of uncertainty, and the challenge of seeing something new and unexplained every day have fueled my enthusiasm to the point where, even in retrospect, I cannot imagine doing anything else.

On the other hand, as a generalist, I have had to put up with a great deal of nonsense from the public and many of my medical colleagues, leading me to ask myself what masochistic proclivity has kept me in the trenches. Perhaps, uncertain of my identity as a physician, I take a kind of perverse pleasure in feeling put upon. The sensation is not peculiar to family physicians. Pathologists, too, fall pray to it, as evidenced by a recent discussion in the Letters section of a major medical journal.[2] Psychiatrists as well have had to defend their right to be regarded as physicians, and Engel's biopsychosocial model of medical care grew, to some extent, out of just such an identity crisis.[3] All of this may explain the chip on my shoulder.

One of the hallmarks of a physician working exclusively in primary care is his or her perpetual status as a student of any and every specialist who happens by. This state of affairs was noted a long time ago by Balint[4] and has not been remedied by academic departments of general practice or family medicine, as their very existence as specialties strikes many people as a contradiction in terms.

The public is quick to pick up on how the general practice physician is patronized by the specialist who does his or her best to perpetuate a teacher-pupil relationship. If one of my patients is annoyed with me, he or she will bring back word of what this consultant or that "let drop" concerning my knowledge base. Another, in a good mood, may tell me that the specialist was pleasantly surprised by my letter and the questions it raised; I actually seemed to have taken a history and performed a physical examination!

Medical students, too, are susceptible to the "message" their largely subspecialist teachers wish to inculcate regarding the competence of those engaged in primary care. The ones who visit my practice have come with the admonition to observe how it is organized; to learn the essentials of teamwork between physician, nurse, social worker, and medical secretary; to determine what information can be garnered from seeing the patient in home surroundings; and to try to understand the impact of disease on the family, and vice versa. No one has ever suggested that there might be some clinical medicine to be learned in the community (a euphemism for "boondocks"), where one can see rubella, pityriasis rosea, and pharyngoconjunctival fever, conditions that may not be encountered in 40 years on the wards. About the most "academic" we ever get is a brief discussion of probabilistic as opposed to possibilistic thinking. It is usually engendered by a proposal to treat a case of suspected sinusitis without ordering an x-ray film, and then back to the safety of the hospital and "scientific" medicine!

My younger colleagues in family practice have, over the years, caused me a good deal of annoyance, measuring themselves against subspecialist contemporaries who are climbing the academic ladder, going off on fellowships, and earning the right to send condescending letters to the local family doctor. They worry about being spread too thin and not keeping up with the latest developments, those very developments that, in a few years, are often proven to have done more harm than good. When this baleful fact comes to light, all the hotshots who originally promoted the gospel and were, in turn, promoted for it, will be getting credit for discovering how bad it was.

Lately, the relationship between medicine and sci-

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ence has been put into perspective for me by an article entitled "Johannes Fibiger and his Nobel Prize for the Hypothesis That a Worm Causes Stomach Cancer." The authors point out that "his story . . . also illustrates the ease with which intelligent and educated scientists can mistake illusion for truth. With hindsight, we can spot the blind alleys of yesteryear, but who can say which are the blind alleys of today?"[5]

For many years I did not know how to answer the doubts of the family physicians who were haunted by a feeling that they would have gone farther had they trained in another discipline. I could only suggest that some thought be given to what they would have lost, but now I can read them the considered opinion of a professor of medicine: "Internists like to talk about excellence. For most people 'excellence' translates into an assertion that internists can deal better with certain medical problems than the family practitioner. There is little objective evidence to support this view where primary health care delivery is concerned."[6]

As family practice specialists, we have dealt with our sense of inferiority in a strange way, forcing entry into academe and then declaring that our credibility there will only be established when we demonstrate excellent research skills. But who is to be the arbiter of this excellence? Our journals invite subspecialists to referee the papers we submit and to judge them in the light of their own narrow windows on clinical reality. There is a kind of self-hatred implied here, as though the whole story of primary care is encapsulated in the indisputable fact that a gastroenterologist will always be more skilled at endoscopy than a family physician and an obstetrician better equipped to handle a difficult birth. The broader aspects of the care we give are ignored by this oversimplification, however true it may be. Nevertheless, we continue to abase ourselves at the shrine of academic respectability, something nebulous that we rely on the other specialists to define.

We are beginning to hear of tenure tracks and protected time even in some of our own departments. The latter is intended, presumably, to keep the promising researcher safe from his or her patients—hardly what family medicine should be about. "Research dominance can be one of the greatest barriers to committed teaching, at least so long as curricula vitae are judged on numbers of published papers. Teaching commitment, if mentioned at all on a CV, is barely noticed. Meanwhile the journals continue to fill with inconsequential material, so that a special skill is needed to spot significant contributions amongst the detritus."[7]

I keep thinking of Thomas Addison and the connection he made between the wasting and asthenia encountered in his patients and the autopsy finding of suprarenal atrophy; arguably his is the most brilliant observation in the history of medicine. There was no element whatsoever of experiment in his discovery, only the meticulous noting and recording of data. No one taught him "methodology" and he did not have protected time except late at night when he might better have slept. The delineation of Addison disease grew directly out of patient care, unsupported by research grants. I have no doubt that there are similiar nuggets still "out there" waiting to be discovered by astute clinicians. If we have not found our share, it is more likely a result of underutilized powers of perception than of having been too busy for serendipity.

Academic departments of family medicine must beware of the growing distance between their activities and the reality in which most family physicians work. I have recently heard physicians who do not belong to university faculty referred to as "community docs." With that, we have developed our own version of the general practice physician, possibly out of a need to feel superior to *someone*!

Much of the prestige accorded the medical profession, and of which we, as general practice physicians, stand in such awe, grows out of an unhealthy penchant for self-advertisement. Almost every evening the news networks treat us to a "breakthrough," suggesting that, long before the present millennium is over, the supply of disease will have been exhausted and members of the human race will find themselves in want of a decent way to die.

If nothing else, we generalists can teach the subspecialists how to get on without an excessive share of glory, not because we are intrinsically humble but because others always delight in having us so. As for myself, what probably keeps me honest is the possibility of supplementing the many rewards of a career in family medicine with the delicious sensation of being insufficiently appreciated, a luxury few consultants can enjoy!

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