

The destiny of general practice: blind fate or 20/20 vision?

We are all interested in the future, for that is where you and I are going to spend the rest of our lives.

Edward D Wood, Jr, director and screenwriter
(from the movie *Plan 9 From Outer Space*)

THIS SECTION of the *MJA General Practice* issue is pure fiction. That is to say, we created a futuristic general practice scenario and asked others to create more of their own. Why should a medical journal resort to science fiction, you ask? The answer: because the future is malleable. If you believe the popular fictions of time travel, you'll know that seemingly minor differences in our actions now can lead to destinies which are poles apart. To help us mould the future, we conceived a section which attempted to generate hypotheses and innovative solutions. We're not contending that the results represent accurate predictions, but neither are these idle speculations. By asking what forces currently drive general practice, we can imagine different futures that test the implications (good, bad and indifferent) of these forces, and advocate change that preserves the good, topples the bad and optimises the indifferent. Here are some driving forces we identified:

The general practitioner

- Gatekeeper of medical care in Australia
- Desire to provide good care for the whole patient
- Health promotion and disease management
- Balancing work and personal interests
- Corporatisation
- Evidence-practice gap
- Information overload, information management
- Threat of litigation, indemnity woes
- Professional and financial under-recognition
- Autonomy versus structural straightjackets (regulation, red tape and time)
- Workforce shortages

The patient

- More informed, with higher expectations of healthcare, its accessibility and affordability
- "Click-fix" mentality of instant gratification
- More likely to have (more than one) chronic illness
- More likely to require coordinated, continuous (not episodic) care

Society

- Ageing and rise of grey power
- Mixing of diverse ethnicities, cultures and values
- More solo households and non-nuclear family groups
- Technological advances in everything
- Knowledge-based economy dictating labour market
- Widening gap between haves and have-nots: rich and poor, technologically literate and illiterate
- More government responsibility shifted to private enterprise
- Continued rise of political conservatism and the far right
- Globalisation of trade and thought
- Environmental concerns and hazards
- Ethical quandaries from technology and inequalities

Nightmare in 2020: a day in the life of Dr Zen, FRACGP

A tired-looking woman is sitting in the medical service bay at Corporation Enterprise (its motto: "Live long and prosper"). The electronic doors open to admit an overweight man. He faces her across a waist-high console. She scans his online medical record with her level 5 clearance. "Mr Unger, you have a five-minute consultation today. How can we help?"

"I don't feel well —."

"Chest pain?"

"No, just not feeling myself. Since my wife died. My complementary practitioner can't help me. Can you?"

"I'll try", Dr Zen replies. She selects the "Social stressor" option on screen. "Which of these symptoms do you have?"

She reels off a list. He replies. They work their way through the appropriate algorithm pathway.

"So, according to our evidence-based, Glerck-Pficham-sponsored guidelines, you have type III depression."

A silent alert flashes on the screen: "Time's up!"

"I'll prescribe you Ease, which [reading from the screen] has been effective in 360 hospital patients. You're also entitled to three teleconsultations with our cognitive behavioural therapist courtesy of Ease." The manufacturer of Ease has a Memorandum of Understanding with Corporation Enterprise.

Dr Zen issues the script and patient education printout. Mr Unger walks out the door, triggering another screen message: "Consultation was two minutes over time — third infringement today. Action 1: repeat practice management module during your Quality and Education session."

Dr Zen sighs. She had wanted to try the clinical research module instead. No wonder GP research in the *Med e-J of Australasia* is so dull: only non-clinicians and corporate administroids have time for it. But who wants to know about health service models and cost analyses?

"Action 2: 5% deduction from today's pay for time infringements."

Yeah, well what about patient care instead of the bottom line for a change? She makes an e-note to mention it again at the next corporation meeting with the Managers. Mustn't put them offside though. They may be heavy-handed but they're the ones doing the real work in general practice — administering new government health initiatives that appear monthly.

Dr Zen is indentured to serve in this busy outer urban centre for another two years. Her husband is rural, but telemedicine clinics are making rural work easier these days. Like most doctors, he'd been put off becoming a GP by his compulsory term in "area-of-need" general practice. But beggars who miss out on other training schemes can't be choosers ...

After her corporate session, Dr Zen drops in on the nurse-practitioner clinic in the slums to see medical referrals from the nurse. This government got in on the promise of "Primary care for the public". But the post-election reality: a teary 72-year-old whose Work-For-the-Aged benefits have been restricted as she can't afford a computer and missed the e-reminder for her Well-70s check.

Dr Zen can't wait to do her taxi shift this evening. Thank goodness for time to talk to customers. It'll keep her going in more ways than one.

Ann Gregory and Mabel Chew
Deputy Editors, *MJA*

I don't try to describe the future. I try to prevent it.

Ray Bradbury, science fiction writer

Next, we wrote a deliberately nightmarish scenario of general practice in the year 2020 (see the Box) showing the negative consequences of some of these forces. We sent the scenario to those involved in frontline and academic general practice, asking them to write short commentaries that

- 1 identified values which had been lost in the nightmare
- 2 suggested how to handle current trends to preserve these values
- 3 offered a better future.

Each commentator was asked to discuss a different facet of the general practice milieu: the consultation,¹ practice manage-

ment,² training,³ workforce,⁴ society⁵ and research.⁶ We believe that the result is a rich vein of thought that shows us there are core values to hold fast and work for. The future need not be beyond us!

We must be the change we want to see — Gandhi

Mabel Chew

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General practice workforce

SOCIOLOGISTS TELL US that “Autonomy is the acid test of professional status... all other characteristics of a profession flow from it”.¹ Poor Dr Zen* has no professional autonomy. Mr Unger’s management is determined, not by her, but by an electronic decision system which then reduces her pay for taking too long and directs her continuing education. How did Dr Zen get into this thankless situation? Let me answer that with some more of her story.

Dr Zen’s dream is to become a Clinical Controller with Corporation Enterprise. Competition is intense as the status and salary are so much better than those of the general practitioners who labour in the corporation’s clinics. To be considered she has to obtain an MBA from the Corporation Enterprise School of Business.

One cold, wet night in 2020, Dr Zen is at a taxi rank waiting for a fare, correcting her first draft of an assignment for the subject HX101 “History of Corporation Enterprise”. The assignment topic is a challenge: “*Why did the GP leaders of 2003 call for policies to dramatically increase the number of general practitioners?*” The course notes suggest that in 2003 the policies pursued by GP leaders undermined real opportunities for GPs.

Dr Zen has undertaken extensive research. Her essay hypothesises that the key mistake in 2003 was not to pursue policy and structural changes so that general practice could adapt in a positive way to changing community expectations. GPs ignored opportunities flowing from technological developments and changes elsewhere in the health system. They

concentrated on defending the status quo and, behind a smokescreen of rhetoric, lobbied government for higher pay for each consultation and for more doctors.² This maintained short-term cash flow but further entrenched structural problems.

The cash flow of most GPs depended on habits developed between 1984 and 2007 under a financing system called Medicare. Medicare rewarded “down-market” activities, not “up-market” skills. The highest incomes came from providing many short consultations and not providing services requiring the very skills that differentiated GPs from other “healthcare workers”. The seriously ill and those requiring minor procedures or time-consuming care drained profits and, under Medicare, could be deflected to specialists or emergency departments.

The network of corporate clinics already emerging across Australia before 2003 grew rapidly following the increase in GP numbers between 2003 and 2007. These clinics were based in the cities and absorbed most new GPs. In 2008, the government admitted that the policy of expanding numbers to get GPs into rural and outer urban areas had failed.

A retired bureaucrat, Gletkin, was commissioned to review the situation. He concluded the government was simply underwriting the profits of a few large GP corporations: the GP workforce was less evenly distributed than in 2003; GPs were being paid for work that could be undertaken more cheaply by others; and the government’s commitment of millions of dollars to educating GPs through six years of university and three years of vocational training was of doubtful value because GPs were not using the skills taught.

The government of Mustapha Mond adopted radical measures recommended by Gletkin. Medicare was abolished and Corporation Enterprise established as a government-owned monopoly. This entity compulsorily acquired all GP clinics and rigorously implemented its charter of ensuring an even distribution of GPs across Australia and providing primary care at

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***See “Nightmare in 2020: a day in the life of Dr Zen, FRACGP” on page 47**

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the lowest possible cost, using protocols designed to refer all serious cases to specialist polyclinics or hospitals.

The company operated to a strict formula of one GP per 1750 people. With a population of 25 million, only 14250 out of 30000 GPs were contracted. Minimal incomes were offered. GPs had to agree to adhere strictly to the corporation's treatment protocols.

The education of GPs was rationalised. School leavers, after five years administrative and assistant experience with the Corporation, could apply for entry to the GP course at the Corporation Enterprise School of Medicine, a three-year web-based course supported by "on-the-job" training. Dr Zen was in the first graduating class.

Dr Zen now understands the sadness on the faces of the elderly couple in the next flat to hers in the Housing Commission complex. They commenced careers as GPs in the early 1980s, full of hope and expectation, but were bankrupted in 2007, when found personally liable for a medical indemnity claim. Since then they had been unemployed. Dr Zen hopes she can afford to buy them a hamper again next Christmas.

Dr Zen is pleased it is a quiet night on the taxi rank. She can think about the conclusion of her essay. Students are asked to imagine a different scenario for general practice after 2003. She

will argue that GPs, rather than squabbling with government over a few dollars, should have thought more deeply about what the community wanted from general practice and how GPs could "add value". They should have lobbied for policy and structural change so that simple tasks could be delegated to other staff, while the highly (and expensively) trained doctors used their skills managing acute medical conditions and common chronic conditions; coordinated the care of patients with complex conditions; enhanced the procedural aspects of their practices; and established arrangements of value to others, such as early hospital discharge. Such a role would have required fewer GPs, but those GPs would have had much more rewarding careers.

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General practice training

Stephen C Trumble and Nicholas J Glasgow

THOSE OF US WHO WEAR SPECTACLES consider “20/20 vision” utterly desirable. The “2020 vision” presented here,* however, is a nightmare that we must strive to avoid.

The story of Dr Zen suggests that several important values have been lost to general practice. Having once been a positive career choice for many medical graduates, in 2020 the discipline is at the bottom of the heap — training in general practice is for “beggars” who miss out on other schemes. No longer valued by other members of the healthcare system, nor practising with any degree of independence, nor able to advocate for her patient, Dr Zen is just a binary drone, condemned to the restraints of protocol-driven diagnosis and algorithmic management. Such reductionism was rejected long before 2020 as a foundation for general practice¹ and other branches of medicine.² Can our elegant craft of hypothesis testing and revision survive alongside the brutishness of digital diagnosis? The primary focus of her attention is the third party paying for her time — what patient would appreciate that? Her clinical independence is severely compromised by the control the Ease manufacturer imposes on her therapeutic decision making. Dr Zen has no supportive collegiate contact, and her supervisors are the sort of managerial bureaucrats who thrive in environments from which general practitioners have been removed. What inspiration for medical students and vocational trainees would Dr Zen’s role provide?

Dr Zen’s Fellowship of the Royal Australian College of General Practitioners still marks her as being competent to practise as an unsupervised GP anywhere in Australia, and she demonstrates this by moving easily between her outer urban push-button practice and the challenges of practice in an inner urban slum (presumably the future Toorak or Darling Point). At least her apparent comfort in working as part of a primary care team with a nurse practitioner makes it sound as though she has been trained in accord with the CanMEDS 2000 principles,³ which describe the GP as a collaborator among other things.

The strength of GP training in Australia has long been its “enhanced apprenticeship” model, the only logical way to impart the values and skills of general practice. This combination of supervised training and needs-focused education allows registrars to practise in a real environment alongside carefully selected supervisors, while receiving relevant teaching from those supervisors and professional medical educators.

*See “Nightmare in 2020: a day in the life of Dr Zen, FRACGP” on page 47

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Although vocational training for general practice has undergone major changes in the past two years, this model has continued. Our approach to training the doctors who will join us in general practice has a huge impact on the future of the profession. So where could we be in the year 2020, and how many of the positive values of the past will carry through to the future?

Dr Zen’s training, re-imagined

The CanMEDS principles, updated, were incorporated by 2020 into a completely integrated curriculum for general practice that guides GP education from undergraduate study through to retirement. This curriculum has enough breadth to address all the disciplines that Dr Zen employs, ranging from population health, evidence-based practice and information management to business management, clinical governance and disaster medicine. Just as importantly, it has the depth to be relevant in any of the contexts in which GPs work, be that in Aboriginal health, a Muslim community, a rural area or the Antarctic. Information technology is a tool in the hands of the competent practitioner, but never a substitute for the practitioner’s “presence”. Nor does real time access to guidelines and algorithms substitute for the vast amount of knowledge about a patient that the GP acquires through careful communication.

Dr Zen’s Fellowship is not the endpoint of her formal learning. She will add a number of graduate certificates, a graduate diploma in preventive women’s health, and a master’s degree in cognitive behavioural therapy to her brass plate over the next decade. The Corporation values the role of the competent medical generalist, incrementally rewarding Dr Zen for the extra competencies she acquires, uses and maintains throughout her career. An exciting career path with the Corporation includes opportunities to contribute to its quality assurance, research and development program and to its education and training program. As part of its commitment to succession planning, continuing professional development activities form part of Dr Zen’s paid contractual arrangements. Her work in the nurse-practitioner clinic is supported by a contract with the government. She enjoys this aspect of her life — different challenges, different demographics and a different team. But her commitment to quality patient care is just as strong.

No taxi shifts for this alternative Dr Zen. Her income is sufficient, her work occupies four days each week by her choice and she has time for her children, friends and social activities.

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Practice management

Mark V Lipscombe

RECENT ATTEMPTS by several corporate entities to secure more of Australia's primary medical care profits have so far been unsuccessful, but it is probably not the last we will hear from them. The 2020 scenario,* far fetched though it may seem, depicts general practice succumbing to the dollar lures of the Corporates. It is a primary healthcare model characterised by heavy regulation, structural division, detachment and constant change. An interventionist government bureaucracy and a ruthless commercial administration have effectively removed all autonomy and personalised attention from the individual's practice. Adherence to strict administrative protocols protects the commercial interests of the company, and both take priority over providing quality primary care.

"Practice management" has become "policy management", and the general practitioner's needs are second to those of business managers who have become slaves to legislative conformity. GPs no longer have support staff to help them provide quality care; rather, the tables have turned and the doctors assist the administration in toeing the company line. As a result, Dr Zen has been forced to compromise on almost every value and ethic crucial to best care.

Today, the profession is witnessing unprecedented bureaucratic proliferation. Multiple regulatory bodies, including federal and state governments, make demands of increasing quantity and complexity. The cost of practice administration, insurance and government regulatory compliance is escalating at an alarming rate.¹ The financial pressure presently being brought to bear on general practice may ultimately precipitate the collapse of bulk billing and "universally accessible healthcare for all Australians".

To prop up a dying primary healthcare system, the federal government may continue to add legislative "patches" that succeed only in transforming a once simple primary healthcare model into one that will ultimately be too complex and financially unsustainable for the medical profession.² At that point, frustrated, overworked and underpaid doctors, no longer able to cope with the administrative convolution and burdensome regulatory demands being forced upon them, will finally abandon their practices in search of an easier way. The attraction of the Corporates lies partly in the promise of inexpensive, efficient, centralised administration.³ Yet, as a profession, we should recognise that a corporation's loyalty necessarily lies with its shareholders and that there are inherent dangers in "selling our souls" to these groups.

Dr Zen's passing self reminder to raise the issue of quality care again at the next managers' meeting is illustrative of the gap that has opened up between our future practitioners and

administrators. An increased administrative complexity demands attention from managers and diverts valuable human resources away from the patient's comfort, confidentiality and care, and from work relationships.

A centralised administration is, by its very nature, one that operates remotely and, in this case, one that uses technology to monitor and control the performance of its human resources. The digital revolution will continue to influence virtually every aspect of our professional lives, but only time will tell if that influence will be for the betterment of general practice. Given the sheer volume of information in which we presently trade, it is inevitable that clinical records will ultimately pass between practitioners exclusively in a digital format. In the nightmare scenario, patient records have become an "online resource", with potential compromise of privacy. Therefore, as we develop systems in which confidential information is exchanged, "secure" communication channels must be among the highest priorities for software developers, the profession and law makers.

At Corporation Enterprise, technology primarily serves the administration by monitoring the activities of practitioners inside the consulting room. Time has become the single most valuable commodity. Quality care comes a distant second to the commercial interests of the firm.

Can we imagine a better future?

2020: extract from television news

The Federal Government and general practice representatives emerged from their latest series of goodwill talks on regulatory reform today to confirm that the future of independent private practice was guaranteed. The restructuring of general practice under the "Red Tape" reform package has seen the elimination of inefficiency over the last three years by removing administrative complexity in general practice structures and payment systems. Outmoded bureaucratic systems were scrapped virtually overnight, and new payments systems, linked to better patient outcomes, were introduced. Dr I M Spock, National President of the AMA, said that "simplified administrative systems combined with a better use of technology" meant that the costs associated with practice would be halved by 2022 and that "the funding crisis could be averted after all". It looks like government-funded universal healthcare is back, and community groups around the country have applauded the initiative. A union representative from the Australian Medical Borg, an army of half-human, half-microprocessor humanoids, said today that "assimilation into this new system is inevitable and resistance is futile".

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*See "Nightmare in 2020: a day in the life of Dr Zen, FRACGP" on page 47

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The consultation

Tim Usherwood

DR ZEN'S FIRST WORDS* capture the context perfectly. She and Mr Unger have a fixed time of five minutes available for their consultation, with penalties for Dr Zen if they run over. Dr Zen inquires how "we", not "I", can help. Chillingly, it quickly becomes apparent that "we" includes not just Corporation Enterprise but also their industrial sponsor of clinical guidelines and the manufacturer of Ease.

Of course, five minutes is never going to give Dr Zen the opportunity to explore the wealth of possible meanings behind Mr Unger's words "I don't feel well". Like many doctors under pressure, Dr Zen takes the patient's first complaint as the principal one, and limits her attention to that.¹ Even using this strategy, it is unlikely that there will be time for much in the way of health promotion during this consultation. This is a pity, as Mr Unger probably consults a doctor rarely, and is at particular risk following his bereavement. And yet Dr Zen, who likes talking with her customers on her taxi shift, tries to encounter Mr Unger as a person.

All good doctors struggle continually to reconcile what have been called the biomechanical and the interpretive aspects of medical practice.² Who would not wish to be offered care based on the best available scientific evidence? Symptom checklists, diagnostic algorithms and evidence-based guidelines provide the basis for optimising health outcomes. Furthermore, we cannot ignore the pressures of time. Even in private practice, every extra minute spent with one particular patient is a minute lost for others in the waiting room.

There is more to care, however, than the efficient optimisation of outcomes. As doctors, by listening to the patient's story we help to clarify and define their distress. By responding empathically we validate it. By exploring and discussing their symptoms we help elaborate their understanding of their bodies, and hence of themselves. Through diagnosis we provide the patient and their family with a vocabulary for their suffering, helping to integrate the illness story into their life narrative. And when we offer a prognosis and treatment, we provide elements of the plot for the patient's story of their future. Doctors who work in primary care, like Dr Zen, have an additional function, that of working with the patient to define what is to be classified as illness — and hence treated as a health problem — and what is to be

regarded as one of the vicissitudes of life.³ Much mischief can arise when patients and their doctors get this distinction wrong.

Although the scenario is fictional, it is an extrapolation, if extreme, of recognisable current trends. The influence of Corporation Enterprise and its industry partners on the process of the consultation is so pervasive that they seem personified in the room.⁴ Dr Zen's agenda is determined almost entirely by the technologies of biomechanical medicine, even though the evidence base she mentions for Ease is quite irrelevant to a bereaved person consulting in a primary care setting. Mr Unger's agenda is crowded out; he is a case to be managed rather than a person to be cared for. The human interaction is constrained and reduced to the minimum needed to define the problem in a form recognised by a third party, and then to provide the matching treatment. And Dr Zen has little opportunity to display the qualities of sensitivity, empathy and compassion that we all need from our carers when we feel anxious and perplexed by illness.

With more time at their disposal, Mr Unger and Dr Zen would have the opportunity to discuss Mr Unger's story of illness in more depth and to consider other issues that might be troubling him. The shared understanding constructed in this conversation might still lead to the illness being labelled as depression, but other, more creative, possibilities might emerge. Perhaps Mr Unger just needs to be heard and reassured, or perhaps he is seeking a new story for his life following the death of his wife. Perhaps, too, Mr Unger has troubling physical symptoms that he is reluctant to disclose until he comes to trust Dr Zen. A richer conversation would provide Dr Zen with health promotion opportunities and a context in which to propose age- and sex-appropriate screening. And Corporation Enterprise might find that Dr Zen prescribes less, while Mr Unger reports greater satisfaction with his care.⁵

Medicine is fundamentally an ethical activity, concerned with right action towards others; doing the right things in addition to doing things right. While diseases can be classified, albeit imperfectly, illnesses cannot; every ill person has their own fears and concerns, hopes and needs, values and preferences. Bioscience provides the tools, but it is in the conversation between persons that the proper use of those tools is defined.

*See "Nightmare in 2020: a day in the life of Dr Zen, FRACGP" on page 47

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Medicine in society

Iona Heath

DR ZEN'S EXPERIENCE of life as a doctor seems much closer than 2020.* Many of her tribulations are already sapping the morale of clinicians in 2003. It is significant that Dr Zen is a woman. We continue to live in a sexist world, and as the medical workforce, particularly the general practice workforce, becomes more and more female, it is likely to become increasingly subject to exploitative working conditions. Those responsible for recruitment into medical school must ensure that all sectors of society are represented proportionately and that men and women are equally represented. It will then be important to try and ensure that women are given equal opportunities within every branch of medicine and that general practice remains equally rewarding and challenging for men and women. The working conditions within Corporation Enterprise seem unlikely to attract the brightest and best medical graduates of either sex.

The clinical encounter between Dr Zen and her unfortunate patient is an emaciated shadow of a genuine, general practice consultation. The doctor is constrained by her management and financial context and by the technology that she is obliged to use. As medical science develops, clinical practice necessarily becomes more difficult.¹ In the future, doctors will need to be more skilful, not less so. As people live longer, more will suffer multiple illnesses, both physical and mental, and will suffer them simultaneously and inseparably. The patient who is overweight, depressed and hypertensive does not have these conditions in separate compartments of his life. He has all three inseparably and he may also be lonely and frightened — all of this is a single condition. The permutations of comorbidity are complex and individual outcomes are always unpredictable.¹ Practice based on algorithms pretends that none of this is true and that healthcare is simple. The reductive use of information technology ossifies the processes of care, stifles innovation and fails to realise the potential of computers to model complexity.

Dr Zen works in a context within which the agendas of the pharmaceutical industry and of government leave no room for the needs of the patient or the professional aspirations of the doctor. The result, clearly seen in Dr Zen, is a loss of enthusiasm for education and the disappearance of original research that is inspired and directed by clinicians. Governments, dependent on systems of democratic voting, are driven by the utilitarian imperative of the greatest good for the greatest number. Within healthcare, we are seeing the rise of a new utilitarianism underpinned by modern epidemiology and imposed through systems of healthcare that are

supported by information technology and sponsored by pharmaceutical companies. This new utilitarianism treats both doctors and patients as standardised and replaceable units, and would have us believe that a smoker is not an autonomous adult who has chosen to smoke but a patient who has been inadequately treated by their general practitioner. The waning of professional power has been regarded as promoting patient autonomy, but its replacement by corporate power compounded by centralised political control seems likely to be much more destructive of individual patient autonomy, dignity and, ultimately, health.

Current health policy is driven by a view of health defined as the absence of disease and measured by the prolongation of life. This view works to the advantage of the pharmaceutical industry. The interests of corporate profit underpin the trends which are already shifting attention and investment within healthcare from the sick to the well and from the old to the young, and replacing care mediated by touch with a system driven by paper and computers. Only a minority of most populations is acutely ill at any one time, whereas the majority are healthy and can be persuaded of a need to take action to remain so by undergoing screening or taking preventive medication. There is more money to be made from selling healthcare interventions for the healthier, richer majority than for the sicker, poorer minority, both globally and nationally.² Similar forces drive the widening of health inequalities seen by Dr Zen in a nurse-led service for the poor and a doctor-led service, however attenuated, for the more affluent.

The events of 2025: people power

Returning to the not so distant future and confronted by the fear that is enduringly implicit in the human experience of illness, we find that the need for a trusting relationship between doctor and patient is so strong that, by 2025, Australia has witnessed the so-called Taxicab Revolt. More and more people realised that doctors like Dr Zen were being forced to supplement their incomes by driving taxis. Frustrated by the minimal and standardised healthcare offered by commercially sponsored organisations like Corporation Enterprise, worried patients began to seek out GP taxi drivers who gave them time to talk about the real extent of their fears and anxieties, and advice about how to begin to sort them out. An alliance was formed which eventually led to widespread civil unrest and demands for a health service free of commercial interference and offering personal and continuing care of named patients by named doctors.³ The alliance bridged social divides and produced a renewed social solidarity based on the recognition that the need for healthcare is fundamental to human thriving.⁴ Different services for rich and poor were no longer acceptable. The rest is history.

Tyranny will always bring forth its opponents as the rain does grass.⁵

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General practice research

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WHAT'S WRONG IN THIS SCENARIO* is that Dr Zen's practice has been hijacked by guidelines, economic imperatives and intrusive technologies. Evidence-based medicine may be a comfort to Zen in the five minutes she has and may improve the look of the annual report of Corporation Enterprise, but the value of her skilled interpretation of the patient's narrative has been ignored. She remains a world away from her patient, with little time to weigh and integrate the research evidence on her screen. Algorithms and hospital-based trials cannot care compassionately for a man grieving for his lost wife, but narrative-based research may provide guidance.

In Corporation Enterprise, the role of team care and the balance between managers and clinicians have been lost. Managers have implemented research-based reforms focused on efficiency, with little regard for the clinical needs of patients.¹ In this context, the relationship between Ease and Corporation Enterprise is dangerously ill-directed and reduces the credibility of Ease's research.

General practitioners are naturalists by training, spending many hours each day observing and summarising the multiple encounters they have with patients. Research that is not patient focused will simply entrench the cultural divide between researchers and practitioners. Dr Zen needs to reintegrate clinical research using observational data into her practice, and this can only happen if Corporation Enterprise revalues such research. To balance her own experience, Zen needs evidence on the natural history of the diverse presentations she encounters and on the use of diagnostic tests, therapies, and screening and prevention activities.² For this evidence to be relevant to Zen, it has to be generated by networks of GP researchers using appropriate information technology.³ Narrative research is also needed, where the patient's story, including where they live

and work, their family, culture, and past health experiences, can form the subject of enquiry.⁴ By its very nature, such research requires the active involvement of GPs like Zen, and it must value their story as part of the final result, just as it values evidence of patient empowerment and preferences,⁵ as well as the more conventional morbidity and mortality measures.

We see that GPs will embrace the world of relevant research, given time, support and leadership. Establishing networks of research practices across Australia with strong and positive relationships with key academic centres and GP divisions is a priority. These research groups need to be cross-disciplinary and embrace multiple methods to answer the complex everyday problems that present in general practice. They must train their members to ask focused and answerable questions. Protected (funded) time is vital for those GPs who want to spend time answering these questions. Three- to five-year career paths for new researchers and passionate visionary mentors are other important elements. Above all, we need GPs to constantly question what they do in everyday practice and feed these queries into these research networks. Clinically important studies will follow. How to manage tiredness in a 55-year-old man, night sweats in a 17-year-old teenager and headache in a 10-year-old girl are some of the everyday priorities facing Zen and all practising GPs for which there is no evidence.

What will the future look like? We hope — with some justification — for something better than Dr Zen's nightmare.

2020: Better findings for GP research

2020 is a good year for general practice research. All 20 established GP research groups, in collaboration with other primary care organisations and consumer groups scattered across Australia, have secured large National Health and Medical Research Council grants, many being cross-disciplinary. Five of the projects from these groups have just won awards for "excellence in societal impact". These new awards were established in 2010 for projects judged most likely to improve the quality of care provided to the community. Twenty new GP and primary care fellowships of five years' duration have been secured. Corporation Enterprise has just announced the extension of a Professorial General Practice position in Primary Care Leadership and Practice-Based Research.

Dr Zen has just logged on to the Professor's website and found new information from research programs on back

*See "Nightmare in 2020: a day in the life of Dr Zen, FRACGP" on page 47

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pain in young men, headache in teenagers and the role of exercise in patients with rheumatoid arthritis. She downloads a new decision support algorithm for the management of tiredness. She emails the professor's personal assistant about a new question she has concerning the palliative care management for her patient in heart failure, and receives a return invitation to apply for funding for protected time to explore the research potential of this question. She takes a taxi home with a smile on her face as she contemplates how to fit this new opportunity into her working life.

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