

The 21st century GP: physician and priest?

At the end of each day, a husband and wife have the 'How was your day?' conversation. He is a GP working in the Welsh valleys; she is a respiratory specialist registrar in a busy teaching hospital. Her stories tend to be vibrant and exciting, regarding such issues as 'emergency pacing', 'thoracoscopy' and the like. On the surface, his are more prosaic, as he tells her of the waiting room full of people who come to share the details of their often unhappy lives, with the vague hope that he may be able to offer some comfort in the form of support, medication, or referral. She suggests that he is acting more as a priest than a physician. She may have a point.

This paper intends to explore this view and to question whether the pastoral skills that good GPs must possess are sufficiently valued by other doctors, patients, medical teachers, as well as those who organise health service provision. We propose that the priest role is one of the many that good GPs need to appreciate and develop.

Historical perspective

The role of the present-day GP has evolved over time from that of an apothecary, who would sell 'cures' and dispense medical advice from his shop.¹ In the days before effective treatments there was little else on offer but pastoral support, listening, and advising. Perhaps this is where GPs have gained their status as important members of the community — a situation which we feel is still important to value.²

The role of the GP gained extra significance as the NHS came into existence when suddenly they were seen as the main provider and gatekeeper of free primary medical care in the UK. The role had not been investigated to any great extent until viewed from the perspective of an outsider who studied doctors in action. The outsider in question was Michael Balint, who coined the phrase 'doctor as a

drug', and considered the benefits, side-effects, and overdose effects of this drug.³ From this perspective, Balint asked doctors to recognise that the GP role goes beyond their medical expertise.

Currently, the training of GPs is systematic and deliberate, encompassing some time in hospital specialties and at least a year in general practice under supervision. GPs are no longer freshly qualified doctors with limited knowledge and skills, but are instead specifically trained in a variety of skills and knowledge in order to deliver appropriate and suitable primary care to a designated practice population.

The softer, less traditional part of this training (featuring such aspects as how to avoid burnout, how to consider one's role in the surgery, and how to manage vague presentations), is often criticised as 'tree hugging'. However, the importance of such training only becomes apparent to the trainee on becoming a fully-fledged, autonomous GP, where perhaps they see their job in a different light.

What do people expect from their GPs today?

We suspect this depends on who you ask. GPs of course play a variety of roles to different people. Some patients expect a quick fix for an irritating malady; others expect some detective work regarding an interesting ailment. Some want an explanation of a longstanding problem, or a translation of the explanations offered by other doctors. To some, we are an administrator, filling in forms and signing prescriptions. To others, a lifestyle guru (or, from another perspective, 'a coercive healthist'),⁴ offering advice about smoking cessation, weight loss, and exercise. Some patients simply want a trusted friend, a detached professional, or a person to talk to in times of woe.

GPs have to address any condition that the patient brings to us. This is genuine

patient centredness, as it is the patient who decides what to bring. Clearly, a significant proportion of consultations do not fit neatly into a specific mechanistic medical box, and cannot be entered as convenient Read codes on our ever-present computerised files.

In the UK, it is increasingly noted that maladies of lifestyle (obesity, stress, alcoholism), are characterised as medical problems. Indeed, even social problems (relationship difficulties, bullying at school, anger), seem to have fallen into the GP's sphere of responsibility. Why do people come to their doctor with these problems? Is it because they value the integrity of their GP and are confident that any advice given will be grounded in common sense? Is it because they believe GPs have been trained in relationship counselling? Or is it, as we suspect, that we are the only impartial people they can think to turn to when life is bad?

Doctor as 'surrogate priest'

There has been a well-documented decline in church going in the UK. The reasons for this are numerous and are for theologians and clerics to address, but of relevance here are the results of the 2005 English Church Census which revealed that 94% of the population do not go to church.⁵

Although we live and work in a multicultural society, the most recent national government census in 2001 still highlighted Christianity as the religion of 72% of the population, with 23% either having no religion, or not stating it.⁶ It is therefore clear that the vast majority of the population are unlikely to have a sufficiently close relationship with their local priest (or other religious leader), to discuss their intimate concerns.

This wasn't always the case — priests would often visit the homes of parishioners in days gone by to enquire about the family's wellbeing. Just like GPs they would be involved in the continuous care of

families from cradle to grave — a local vicar may have married a young couple, baptised their children, prepared the children for confirmation, and taken a funeral service for one of the grandparents. In this way they would become familiar with the social dynamic of the family and the needs of the local community, and be well positioned to counsel in times of difficulty, such as bereavement.

Priests would also be trusted enough to be told confessions, in the hope of forgiveness (a role not confined to the Catholic church). GPs are not in the position to provide religious absolution, but we are frequently privy to a multitude of 'sins' (for example, adultery, illicit drug use, fighting), by nature of our confidential relationships with our patients. A priest may have also played a pivotal role in somebody's life in times of despair, with the proclamation that 'new beginnings' are always possible: a central theme in many religions. In this way, they may have been able to successfully inject hope into an otherwise desperate situation.

Priests and other religious leaders clearly still play these important roles today, but to a much lesser extent. There are several possible reasons. Firstly, up to a fifth of the population don't have a religion. Secondly, most people in the UK don't engage with a place of worship, even if they describe themselves as religious. Thirdly, priests (like GPs), are expected to perform a great deal more functions than was previously expected of them, and simply don't have as much time to spend drinking tea and chatting with parishioners.

The spiritual role that used to be in the domain of the priests is now thrust into the medical sphere. It forms an essential part of the quadruple diagnosis in palliative care — biological, psychological, social *and* spiritual.⁷ It is our belief that patients have, in recent times, tended to bring more distress to doctors because of the primacy in western culture of the

medical/rational/scientific model over the spiritual model.⁸ We also contend that GPs as 'pillars of the community' are now the default sources of comfort for issues such as bereavement, social isolation, and loneliness.

We see the pastoral role as no less important than our medical roles. It is the realisation of the objective stated on our applications to medical school that 'we want to help people'.

As GPs, we can help by listening to people and being interested in what we hear. It is this humanity that our patients value the most,⁹ and studies into patients' expectations of GPs place 'support' second only to 'explanation of the problem',¹⁰ indicating that empathy within this pastoral role is not just valued, but also expected.

Is this role valued or recognised by others?

There is surprisingly little research into the opinion of hospital doctors of GPs, but much anecdotal evidence. A survey by Marshall,¹¹ suggests a good level of mutual respect between GPs and hospital consultants on the whole, but with some striking differences of opinion. More than a fifth of specialists felt that higher calibre students should preferentially become hospital doctors rather than GPs, and 17% felt that the main role of GPs was to act as a filter to hospital services.

However, GPs are subjected to a broader range of issues than any other branch of medicine, and most hospital specialists agree that they would not be able to transpose their skills easily if they were to work in primary care. A recent report indicated that most doctors are not prepared to answer questions such as 'what would you do doctor?'¹² We contend that GPs are more often placed in this situation compared to other doctors and that our patients would prefer an answer from us. Essentially, GPs may have limited

preparation for these issues from their postgraduate training, and this role may be difficult to prepare for, but it is nevertheless important.

Is the situation changing?

The role of the GP is evolving, and some argue not always for the better. In their *BJGP* editorial, Mangin and Toop¹³ suggest that by striving to reach our QOF targets we risk losing our reputation for integrity among our patients. This may be true, but the overall principle of improving population health by encouraging, for example, tighter control of risk factors, is surely honourable. Similarly, GPs cannot be criticised for meeting these targets and claiming their reward for doing so, as even the most altruistic GPs are not going to turn down this golden opportunity to improve their income, especially if the QOF points are based on evidence of benefit to patients. We recognise that the word 'evidence' has issues of interpretation and is often not as clear cut as is usually inferred.¹⁴ However, we also postulate, provided that targets are evidence based and we do not allow ourselves to become distracted by them, there is no harm in QOF points, as long as the powers that be are aware that they do not represent all of our workload. It is this issue of 'measuring the immeasurable', which has led to views that QOF is overly dominating medical encounters.

Conclusions

GPs are of course doctors. The conversation at the beginning of this piece could have given the impression that hospital doctors dismiss the GP role as 'merely' a priest. The tenor of the conversation was merely to reflect that it takes all kinds of medical expertise to provide comprehensive and continuous NHS care to all our patients. GPs need to be equally adept at applying the scientific principles of medical practice as their hospital colleagues, but they should also

be willing and able to provide tree hugging, holistic, and pastoral care.

Of course, this variety of care is the very essence of general practice, and why many of us entered the profession. Clearly our patients utilise these roles and skills as they feel most appropriate. A significant proportion of our work is now measurable in terms of quality. The challenge is to highlight the significance of the immeasurable to our hospital colleagues and NHS policy makers.

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REFERENCES

1. McWhinney I. *A textbook of family medicine*. Oxford: Oxford University Press, 1996.
2. Jacobson L, Hawthorne K, Wood F. The 'Mensch' factor in general practice: a role to demonstrate professionalism to students. *Br J Gen Pract* 2006; **56**: 976–979.
3. Balint M. *The doctor, his patient and the illness*. London: Pitman Medical Press, 1957.
4. Skrabanek P. *The death of humane medicine and the rise of coercive healthism*. London: Social Affairs Unit, 1994.
5. Christian Research. The English Church Census 2005. <http://www.christian-research.org.uk/intro.htm> (accessed 10 Sep 2007).
6. Office of National Statistics. 2001 census data: <http://www.statistics.gov.uk/CCI/nugget.asp?ID=1086&Pos=2&ColRank=1&Rank=326> (accessed 10 Sep 2007).
7. O'Neill B, Fallon M. ABC of palliative care: principles of palliative care and pain control. *BMJ* 1997; **315**: 801–804.
8. Barritt P. *Humanity in healthcare: the heart and soul of medicine*. Oxford: Oxford University Press, 2005.
9. Cheraghi-Sohi S, Bower P, Mead N, et al. What are the key attributes of primary care for patients? Building a conceptual 'map' of patient preferences. *Health Expect* 2006; **9**(3): 275–284.
10. Williams S, Weinman J, Dale J, Newman S. Patient expectations: what do primary care patients want from the GP and how far does meeting expectations affect patient satisfaction? *Fam Pract* 1995; **12**(2): 193–201.
11. Marshall MN. How well do GPs and hospital consultants work together? A survey of the professional relationship. *Fam Pract* 1999; **16**(1): 33–38.
12. Sokol D. What would you do, doctor? *BMJ* 2007; **334**: 853.
13. Mangin D, Toop L. The Quality and Outcomes Framework: what have you done to yourselves? *Br J Gen Pract* 2007; **57**(539): 435–437.
14. Jacobson LD, Edwards AG, Granier SK, Butler CC. Evidence-based medicine and general practice. *Br J Gen Pract* 1997; **47**(420): 449–452.

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Our schedule has taken us from the Duke's Hall of London's Royal Academy of Music to the Atheneum in Bucharest, to the Great Hall of the Liszt Academy in Budapest. As the programmes have become more taxing, so does the orchestra shrug collectively in amused disbelief as it hears what it is expected to play next — as, for example, in this summer's concert in the beautiful Berlin Konzerthaus. We played Berlioz *Carnaval Romain* overture, a fizzing orchestral showpiece if ever there was one; the orchestra, greatly scaled down — and horribly exposed — accompanied the Strauss oboe concerto, and the concert ended with Mahler's First Symphony. For most of us, this was the high point of the entire weekend with many united in tears at its beauty and tragedy, its irony and angst. In November we return, for the third time, to the Duke's Hall with another huge

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Michael Lasserson

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