General Practitioners in the Twenty-First Century

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Abstract: The health care of the twentieth century was characterized by its key concept, cure, i.e., curing disease with medical technology. As a result, specialists, i.e., physicians trained for cure, were highly valued, while general practitioners, i.e., physicians trained for care, were neglected. This tendency was especially notable in Japan. In contrast to Western countries, general practice is not recognized in Japan as a specialty. However, as the technology for cure has advanced, the following problems have emerged: 1) medical technology is still limited, 2) new medical technology is inefficient, 3) medical technology increases the number of patients, and 4) medical technology increases economic inequality. Since these problems have shown that it is impossible, both technically and financially, to solve all of the problems of disease by cure-based health care alone, it is necessary to acknowledge that care-based health care was the basis of health care for thousands of years, and to recognize general practice as an essential part of health care.

Key words: General practice; Cure; Care; Specialty; Medical technology

Introduction

To have a prospect of the health care in the twenty-first century, one must review the twentieth century health care, and general practitioners’ broad perspective is essential. This article first presents general practitioners’ views and perspectives. It then describes the characteristics and problems of twentieth century health care based on them. Finally, it concludes that the role of the general practitioners, which was neglected in Japan throughout the twentieth century, should be properly appreciated in twenty-first century health care.

General Practitioners as Specialists

1. Wisdom in ignorance

Statements such as “general practitioners are specialists” and “this is a normal abnormality”
are perplexing, because they are contradictory. However, being contradictory is one thing, and being wrong is another.

For example, we are familiar with the phrase “wisdom in ignorance”, which means that true wisdom lies in acknowledging one’s lack of wisdom. Socrates persuaded his dialogue partner that parading one’s knowledge was vain, and demonstrated that he possessed true wisdom because he frankly confessed that he was ignorant.

This story provides a lesson: while a phrase such as “wisdom in ignorance” is outwardly contradictory, it makes sense when examined from a different viewpoint.

“Normal abnormalities” is a phrase invented by the British general practitioner John Fry, who claimed that some of his patients presented symptoms that he would call “normal abnormalities”. He insisted on simply observing them instead of trying some treatment. For example, a fever is an abnormality, yet recent studies have revealed that it is a very important biological defensive reaction. Endogenous pyrogens have been found to be identical to interleukin-1, the information-relaying substance related to immune reactions. Thus, a fever and immune reactions are the “two sides of the same coin” in biological defensive reactions. Another example is pain. Pain can be interpreted as a defensive reaction to prevent further damage to injured parts. Fever and pain are indeed abnormalities, but when looked at from different viewpoints, they are sound reactions directed at the recovery of health.

2. General practitioners as specialists

Then what about the statement, “General practitioners are specialists”?

This statement is unwarranted in Japan, because general practice is not recognized as a specialty here. Some other countries, however, officially recognize general practitioners as specialists. In the U.K., for example, the Todd report recognized general practice as a specialty in 1968. In other words, general practitioners are recognized as specialists in the U.K. In Germany, too, Allgemeinarzte were recognized as specialists in the same year, and one can no longer be a health-insurance physician there without this qualification.

If general practitioners are to be recognized as specialists whose role cannot be assumed by members of other fields, then health care in Japan must be in dire straits. For example, if a lack of specialists in a particular field, e.g., dermatology, forces specialists in other fields, e.g., internists, surgeons or pediatricians, to serve in dermatology, such a health care system cannot be called first-class.

The statement “general practitioners are specialists” is apparently contradictory. Nevertheless, as in the case of “wisdom in ignorance” and “normal abnormality”, we cannot reject it as erroneous. Instead, we need to consider why Europeans countries have accepted it.

3. The whole is not simply the sum of its parts

The difference between general practitioners and specialists is that while specialists deal with particular parts of health care, general practitioners cover the whole field. What then is the relationship between the “whole” and the “parts”? The Iwanami Dictionary of Philosophy defines the “whole” as follows:

Antonym of “parts”. The whole consists of parts, and parts are the elements that make up the whole. (1) When the whole is considered to be just the sum of the parts, then the whole does not have any meaning of its own. (2) When the parts which make up the whole are combined in correlative or interdependent relationships, then the whole is more than just the sum of its parts, and each of the parts loses its meaning if separated from the whole.

The phrase “the whole is more than just the sum of its parts” in this definition is notable. This concept seems to provide grounds for thinking that general practitioners have a unique role and are specialists. Here we are reminded of Gestalt psychology. “Gestalt” means significant totality made up of components or elements.
The meaning of “whole” varies according to how we view it and how we think of it. There are things that can only be understood by examining them from several viewpoints, and by unifying the observations. Unified views, obtained in this manner, are more than just the sum of their components. Thus, general practitioners’ broad perspective is helpful to observe things from different viewpoints, and to think flexibly. In other words, they are good at accepting concepts such as “wisdom in ignorance” and “normal abnormality”. In order to cover the whole field of health care, as general practitioners are expected to do, we should look into our inner world, i.e., our total image of health care, as well as examine the systems outside.

The Gestalt of Care

1. Limitations of knowledge and technology

When Tetsujiro Ihara entered the medical department of a British university, he was full of ambition. However, he was shocked by the speech of the dean of the medical department given at the orientation for new students:

The mortality of human beings is one hundred per cent, i.e., death occurs universally, and our medical knowledge is limited. The most important thing that medical students should learn in the medical department is how limited his or his colleagues’ medical knowledge is, and how to behave and speak as health care experts.

Upon hearing this, Ihara became angry. Yet, in the course of his first two years in the medical department, many sessions were held on this issue, and in the end he came to support the dean’s view. He stated in retrospect “when I entered the college, I did not understand how important the idea of ‘wisdom in ignorance’ was”.

The dean’s speech was characterized by observation of health care from a viewpoint, different from the traditional Japanese viewpoint. His attitude is comparable to that of appreciating “wisdom in ignorance”. If so, what behavior and way of speaking are suitable for health care experts who are aware of the limitations of medical knowledge and technology?

2. Health care before modern medical science

Lewis Thomas is an American medical scientist and an essayist. In his essay “Medicine as a Very Old Profession”, one of the four essays at the beginning of The Cecil Textbook of Medicine, he skillfully describes how health care changed over the course of the twentieth century. He described his father, a typical early-twentieth century physician in private practice. He said:

During all his years in general practice he possessed only small bits of science . . . .

Not to say that treatments for illness were not used by doctors, but these were more like gestures of reassurance, sometimes like incantations of amulets . . . . but neither my father nor other doctors of this time had any real faith in them [ = drugs] . . . .

I was taught at Harvard Medical School, as my father had been taught at Columbia, that treating disease would be the least of my future responsibilities. The doctor’s job was to recognize the nature of disease with precision, and so that he could explain to the patient, and to the patient’s family, what was happening to him and how it was most likely to turn out.

This task, the explaining of illness, was the most important part of what was then called the art of medicine. It still is. Indeed, it has been a central duty of medicine, justifying all those millennia of the profession’s existence, dating all the way back to our origin in shamanism.

This description seems to be an example of the British dean’s idea of “how to behave and speak as health care experts”. Lewis Thomas also said, “I remember a short story from real life which illustrates an aspect of the responsibility of doctoring which does not find emphasis in many textbooks of medicine”, and told the story. It is a concrete example of the idea that the British dean presented.

Lewis Thomas visited a medical society in a
remote rural area to give a lecture on antibiotics. The president of the society was a man in his forties. He had just been officially inducted into the office of president, and had his lecture ready for the occasion. However, when the meeting began, he was handed a note and went out to answer a phone call. He returned three hours later. He looked tired, worn out and disappointed to have missed what should have been his own professional triumph. When Thomas asked what had happened, the president answered that he received a phone call from the family of an elderly patient, informing him of the patient's death.

The president thought, in Thomas’ words, “he ought to be there, to help the family, and to be useful. He simply had to be there”.

Thomas concluded as follows:

This was about 30 years ago, but I’ve never been able to forget that doctor and his example of good doctoring that evening. It’s not quite the same thing as open-heart surgery or curing meningitis, but if I were looking around for a role model for today’s medical students to look at very closely, I’d pick that country doctor in the backwoods countryside of Mississippi, if I could find him.

3. **Cure and Care**

John Fry pointed out that health care has two purposes, *cure* and *care*. He listed the following as keywords of *cure*: “science, clinical, biological, physical, disease, body and hospital”, and contrasted them with the keywords of *care*: “art, pastoral, behavioral and social, emotional, person, soul and community”. He also said that it was wrong to think of the former as first-class and the latter as second-class, and that neither must be provided either “too much” or “too little”.

In summary, *cure* solves the problem by curing the disease, while *care* helps patients to accept their disease when physicians cannot cure or control it. The former corresponds to Lewis Thomas’ example of open-heart surgery and curing meningitis, and the latter to the president of the medical society in the remote rural area of Mississippi.

However, the term *care* is also used in a broader sense to mean health care in general, as in “primary care”. Here, “primary” means “at the first stage”, and “care” means “health care”. Thus, the idea of *cure* can be included in a broader sense of *care*. In other words, “*care* (in a broader sense) = *cure* + *care* (in the narrower sense)”.

4. **Revaluation of Care**

By examining the history of health care with the keywords *cure* and *care*, we can summarize it as follows:

1. For thousands of years after the beginning of health care
   — health care characterized by *care*.
2. For several centuries after the birth of modern science
   — health care characterized by *care* (the preparatory period for *cure*).
3. The twentieth century (especially the second half)
   — health care characterized by *cure*.

Thus, the second half of the twentieth century was the first period of *cure*-based health care in history. In a historical sense, it can be called a very exceptional period.

Moreover, the period characterized by *cure* was a period when *care*-based health care was neglected. This tendency was especially notable in Japan. For example, are we teaching today’s medical students the importance of the view that the British dean expounded in his speech and of the behavior shown by the president of a local medical society in Mississippi?

At the beginning of the twenty-first century, we are confronted by various problems in health care. Since many of these problems emerged as *cure*-based health care developed, we need to examine *cure*-based health care in comparison with *care*-based health care, in order to cope with them.

I think that we should begin with reviving the Gestalt of *care* in order to set twenty-first
century health care on a good course.

Problems of Medical Technology

1. Problems of medical technology
   What we expect of health care is cure of disease with medical technology. However, we can point out the following problems with the medical technology:
   (1) Medical technology has its limitations.
   (2) New medical technology is inefficient.
   (3) Medical technology increases the number of patients.
   (4) Medical technology increases inequality.

2. Medical technology cannot solve the problems
   Today it is generally held that we can cure many diseases with medical technology. For example, we can cure many infectious diseases with antibiotics.
   However, most of the mild viral diseases that we see in our clinics are better described as healing naturally, rather than being cured by us. This part, “healing naturally”, is something that medical technology cannot deal with, and that is outside physicians‘ control. In reality, however, this fact has been neglected with the excuse that treatment ends in a favorable condition.
   For example, a mild injury of the fingertips will heal if we disinfect and bandage it. Yet, what heals the injury is the regenerative power of the skin, and not the disinfectant or the bandage. The regenerative power of the skin is quite magical, and physicians cannot control it easily. For example it is impossible to make an injury heal in a day or two that takes a week to heal by itself.
   The sixteenth-century surgeon Anbroise Paré said, “I dress a wound, and God heals it”. This phrase is still valid in the practical scene of health care today, and it will continue to be in the future. The extent to which medical technology can solve problems is limited. We need to reevaluate an alternative solution, i.e., care.

3. New medical technology is inefficient
   Scientifically justified and truly effective remedies have been invented over the past several centuries. Today, at the beginning of the twenty-first century, the areas where medical technology is effective have been exploited, and only technically difficult areas remain. As a result, in terms of the balance between cost and benefit, recent medical technology seems to be becoming increasingly inefficient. For example, examination of the following list of treatments, “improvement of living environment, vaccination, antibiotics, surgery and transplantation” reveals that as one proceeds down the list, the medical expense increases and the number of patients saved grows smaller. This tendency is expected to accelerate.

4. Medical technology increases the number of patients
   Before there was any concept of blood pressure, people with high blood pressure were not thought to be a problem. Similarly, the phenomenon of elderly people becoming bent over was not recognized as an illness. Yet, as medical knowledge increased, these diseases came to be labelled “hypertension” and “osteoporosis”, respectively. Thus, people who used to be classified as healthy are now regarded as ill. As the technology of genetic diagnosis advances, everyone will be found to have defective genes, and no one will ever be described as healthy any more.
   John Fry said that health was a fantasy. According to him, “health is a rare subjective state of mind and even more rare objective physical state”. Thanks to this fantasy, he claimed, expectations of health care would grow enormously, and medical expenditures would increase forever.
   Fry summarized the problems of today’s health care in the form of “insoluble equation of health care”. He said:
   
   . . . our wants always will be greater than our needs, which always will be greater than our available resources.
If this insoluble equation is to be believed, then we should pursue efficient and fair management within a limited medical budget.

5. Medical technology increases inequality

As medical technology becomes more costly, access to health care depends on whether patients can afford it. This is an issue that cannot be neglected from an ethical standpoint. Thus, as medical technology developed enormously in the second half of the twentieth century, health insurance systems were introduced in various countries. At the same time, health care no longer remained a matter between physicians and patients, but an important political issue.

As medical technology advances, this issue will become more and more serious. Today’s health care problems in Japan appear to lie in this context.

Health Care in the Twenty-First Century

1. Basic ideas of twenty-first century health care

The second half of the twentieth century was a period when traditional care-based health care shifted to cure-based health care. A different style will be needed in the twenty-first century, and the basic concepts of the twenty-first century health care will be as follows:

(1) Cure-based health care is reaching its limits, both technologically and financially.

(2) Care-based health care has been the basis of health care over thousands of years of history.

(3) Health care in Japan must be reorganized based on the care-based system.

(4) General practitioners, i.e., specialists in care-based health care, are essential to twenty-first-century health care.

2. Measures to cope with the problems of cure-based health care

In cure-based health care, medical technology is sought to treat patients. But, since inequality has increased with it, we must cope with this problem. In Japan, we have coped with it by means of Universal National Health Insurance. Nevertheless, the development of medical technology has promoted the condition which John Fry called “the insoluble equation of health care”. Accordingly, it has caused medical expenses to increase. As a result, it became difficult to keep health care services fair. This is the source of today’s problems in medicine.

We are forced to design a system to provide health care services that is as fair as possible under the conditions of “the insoluble equation of health care”. If we fail to cope with it, medical technology will not benefit us, but disappoint patients.

More specifically, we have to cope with the following issues:

(1) Classifying the demands of patients.

(2) Accepting a certain degree of inequality.

(3) Establishing a health care system based on primary care by general practitioners.

(4) Establishing a qualification system for specialists, including general practitioners.

(5) Rejecting excessive expectations (or “fantasy”) in regard to health care.

(6) Reviving the concept of care (or “common sense”) in health care.

3. Index of fair and unfair health care

(1) Evidence-based medicine (EBM)

In concrete terms, the main issue in today’s health care is how to keep health care services fair with limited medical expenditures.

This has been long discussed in the U.K., a leading country in the field of health insurance system. What has resulted in the discussion was the idea of the evidence-based medicine (EBM). As shown by the dean’s speech quoted above, the U.K. has a tradition of acknowledging the limitations of medical technology, and viewing its effectiveness critically. This tendency became conspicuous because a new target, i.e., maintaining fair health care services within a limited medical budget, was newly
added. For example, Archie Cochrane, famous for the “Cochrane Collaboration”, defined his basic concept as follows: “because resources would always be limited, they should be used to provide equitably those forms of health care which had been shown in properly designed evaluations to be effective”. In its basic concept, therefore, EBM accepts inequality in medical treatments whose effects have not been proved.

(2) Numbers needed to treat (NNT)

EBM includes the concept of “number needed to treat” (NNT), i.e., how many patients physicians have to treat to save one. For example, not all hyperlipemia patients develop ischemic heart disease. The fewer patients develop the disease, the higher NNT is. The higher NNT is, the lower the risk that patients develop the disease.

We are at risk of traffic accidents and of various problems related to our life style. If the risk of a particular disease is less than these risks, we can exclude it from the list of the targets of fair health care services.

(3) Cost versus benefit

In terms of cost and benefit, we should give priority to inexpensive services as the target of fair health care services, rather than expensive services. The total medical budget decides the extent fair health care services can cover.

Conclusion

Disease cannot be cured: this is the starting point of health care. Before the first half of the twentieth century, it was technologically impossible to cure most disease, but in the second half of the twentieth century it became more or less possible to do it. In turn, financial problems have occurred in today’s health care.

When technological aspects matter, the results of treatment depend on patients’ luck. When financial aspects matter, however, they depend on patients’ economic power. Moreover, while under the capitalistic, or free economy system, everyone has an equal chance to earn. Since the results are not always equal, differences in income determine accessibility to health care. One might accept one’s misfortune, if a matter of luck, but is it acceptable in the same manner if it is a matter of economic power?

Since developments in medical technology inevitably cause inequality in health care under the capitalistic system, we must design a health care system that will mitigate the inequality as much as possible. At the same time, we must acknowledge that we cannot cure all the diseases. Therefore, we need to reevaluate the concept of care as a final solution in health care for some incurable diseases.

Today, the need for informed consent is emphasized as a means of allowing patients to choose remedies independently. However, as Lewis Thomas stated, the explanation to patients is a far more fundamental part of health care.

Accordingly, physicians must be familiar with the disease themselves to be able to explain it to their patients. They need not merely medical knowledge, but a view and perspective based on the concept of care. They must explain to their patients what is happening, and how it is most likely to turn out, with sympathy towards the patients’ suffering. They also have to explain how limited medical knowledge and technology are.

Revaluation of general practitioners, i.e., specialists in care-based health care, is essential in the health care system of the twenty-first century.

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