Between 'thisness' and quiddity:

the place of the GP

The role of the GP is to apply their knowledge of medicine, science, the arts, to an individual patient in front of them. Two philosophical concepts from the 13th century can help us here. 'Thisness,' 'haecceity' is the characteristics of the being that make it that particular being. The thisness of my dog lies in the way she wags her tail, prefers ball games even to food, twitches her nose; all the things that make her just herself and not another dog. All things have thisness, not just people and dogs. A rock will have an individual essence which makes it just this rock and not another one. The 13th century philosopher Duns Scotus[1] popularised the notion of haecceity, adapting it from Aristotle, and he has had many admirers down the centuries, including the German philosopher Martin Heidegger (who in 1915 wrote his habilitation thesis on the philosophy of Duns Scotus.) But it was the Victorian poet and Jesuit, Gerard Manley Hopkins, who coined 'thisness' as an English word meaning haecceity. He memorably uses the concept in his poem *As Kingfishers Catch Fire*:

' ... Each mortal thing does one thing and the same:
... myself it speaks and spells,
Crying What I do is me: for that I came ...'[2]

Quiddity is in some ways the opposite. This is those characteristics a dog shares with other dogs that make it a dog, a table with other tables that make it a table. Now science studies precisely this, the things we share in common so that a treatment that works for one man may work for all. As GPs we take a treatment that works in general and see if it is appropriate in a particular person. Evidence-based medicine acknowledges this when it says that you should consider whether the patient in front of you is like the patients in the trial; in terms of age, sex, and place of care (that is hospital or primary care). These categories do belong to the thisness of the patient before you, as opposed to the quiddity, but they are poor categories. By poor categories I mean they do not take you very far in describing the particular person in front of you and therefore in deciding whether that particular treatment will suit him. We need a richer picture of the individual human being. I have written earlier of the numerous and conflicting meta-narratives with which post-modern man may seek simultaneously to understand the world.[3] It is certainly worth becoming aware of these by listening carefully to the patient: by eliciting their thoughts, beliefs, and expectations as we tell our trainees. However the privileged way to access the thisness of a patient is by dialogue; together we can struggle to work out if the proposed treatment is a suitable treatment for this patient. Our thisness does not lie in the mind alone but in our social role and in our body. Can this person open this pill-bottle; can he read or remember instructions, what are his pharmacogenetics? This dialogue is clearly an iterative process; when we talk to the patient we move between quiddity and thisness, the general and the particular, until we agree on a best course of action.

Interestingly, in designing treatments, modern Western medicine starts from quiddity whereas traditional therapeutic systems start from thisness; they consider what is individual about the patient and base their treatment choice on this. For example, according to Michel Foucault, the medieval Western physician would design his treatment starting from the health beliefs of his client.[4]

The motto of the Royal College of General Practitioners is *Cum scientia caritas*. *Scientia*, in this context means knowledge, knowledge about the general properties of things, their quiddity. *Caritas* simply means love. Love implies not only grasping the thisness of the person in front of us, but choosing to act in a way that respects this. To grasp the thisness of the person in front of us we need both intellectual and emotional empathy. Intellectual empathy means understanding their situation from their point of view. Emotional empathy means feeling the emotions they feel. In the jargon of psychoanalysis this is called counter-transference. In everyday practice it simply means that I become aware that I am feeling anxious or angry or depressed and realising that this is a clue to what the patient is feeling. Love is not love that is empathy alone, it must lead to action, but action now attuned to the world of our patient rather than our own.

To summarise the role of the GP is to apply his knowledge, which relates to humankind in general, its quiddity, to the individual before him in all his glorious thisness and eccentricity. This is a very general description of which I have only sketched some consequences here. However it means that we have a job that is unique and irreplaceable. The more our scientific knowledge increases the more this role will be needed. At a time when some GPs feel disorientated, this role is something clearly needed which we are good at and can be proud of. Of course GPs do many other things; running practices, rationing the health service and so on. But we should not be seduced into making these more important than what I see as our prime and irreplaceable role; interpreting quiddity to thisness.

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