Family practice: the renaissance is over*

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Introduction

IN the early seventeenth century, Jean Baptiste van Helmont argued for a new science of chemistry in medicine and found himself in opposition to the church, the medical schools and even the more occult followers of Paracelsus. He issued a challenge to the dominant Galenists of the day which, while never accepted, serves as an example of the exasperation known to all reformers:

> "Let us take out of the hospitals, out of the camps, or from elsewhere, 200 or 500 poor people, that have fevers, pleurisies, etc. Let us divide them into halfes, let us cast lots, that one halfe of them may fall to my share, and the others to yours: I will cure them without bloodletting and sensible evacuation . . . (and) we shall see how many funerals both of us shall have" (Debus, 1978).

We may smile at his experimental design but we cannot fault his experimental spirit, and we cannot fail to identify with his feelings. Unfortunately that is not the way most medical debates get settled—even now.

During the past 15 years general/family practice has experienced a rebirth that in its own way has involved us in conflict with the dominant powers in medicine. We do not debate the scientific basis of chemistry in medicine and all that it stands for, but we have serious questions about the adequacy and appropriateness of a medical care system wholly devoted to a molecular understanding of the human organism, and we stand against a dogmatic and stultifying scientism that abjures all other dimensions of human experience. Our renaissance was fomented by problems in the distribution of medical and health services that arose in part from this limited view of science and its application to the clinical needs of people. In one sense our issues are not the same as van Helmont's, but in his struggle against dogmatism and power we are his kin.

The opposition to general/family practice has come mainly from medical schools, hospitals and other specialty organizations. Even though we have secured an academic beach-head within most of the public medical schools, on the whole they are not keen to identify themselves as schools for family doctors, though they cling tenaciously to the myth of the undifferentiated doctor as the typical product of their undergraduate curricula. Hospitals and specialty organizations have been vigilant to see that family doctors are either excluded or severely limited in their access to the high technology of medicine.

The battle for status within medicine has largely had the effect of confusing the general public, and they look on with increasing impatience; by and large, they do not understand what all the fuss is about, why they cannot have both high technology medicine and personal medicine when they need it.

Clearly, general/family practice exposes a nerve of great sensitivity in the body politic of medicine. To some it seems retrogressive and anti-intellectual, to others simply impossible; they do not understand how a general practitioner of any type can keep up with the explosion of medical information and they cannot get past the notion that one must be a 'super doc'—a feat that is manifestly impossible except for a few geniuses.

What now that the rebirth of general/family practice has occurred? Where do we go from here now that we have emerged from a long gestation and can see the light of a new day?

Challenges of the 1980s and beyond

There are two sets of challenges facing us in the 1980s and beyond. One of these is the problem of how our vocation becomes institutionalized in the various national medical care systems where it exists; the other is what we (and our publics) understand the work of the family doctor to be.

Institutionalization

The Millis Report (Citizens Commission on Graduate Medical Education, 1966) (Millis, 1970) observed

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that general practice failed in the USA in the first half of this century because it had not made a place for itself within the organizations of medical education and medical care; that is to say, it did not develop any necessary role within the system. What we experienced from the mid-1930s until the early 1970s was a steep decline in the number of general practitioners and an erosion of their role. Everything, it seemed, that the public needed by way of medical care could be provided by the burgeoning specialties working in and around hospitals. We lost generations of medical students to other specialties, a fact that still plagues us in the small number of general practitioners over the age of 50. It will require decades to repair the damage done to general practice in the USA in the years from 1935 to 1965. This decline did not occur to the same extent in most other countries and this perhaps accounts for the greater sense of urgency in the development of the family practice movement in the USA. We have been trying to save ourselves from extinction.

Millis saw very little hope in trying simply to preserve or resurrect the traditional general practitioner. He called for a new model of the generalist, which after some debate he labelled the 'primary physician', a generic category of which the family doctor is only one species. Millis (1970) said that ". . . if there had not been a general practitioner in the past, we would now have to conceive and educate the primary physician *de novo* for the future." However, in spite of understanding the problem of institutionalization, Millis unfortunately had no prescription that would alleviate the problem for the new primary physicians, who continue to live in uncertainty and ambiguity about what and where their job is, how they are to be paid and for what.

Hospitals and general practitioners

The hospital is the dominating centre of medical practice and power; it controls most of the technology of modern medicine and determines what services insurance companies, federal agencies and other third parties are willing to pay for. The role of the family doctor in the hospital is no clearer today than it was 15 years ago when the modern family practice movement began. Defining this role remains one of the chief items of unfinished business for family physicians, hospitals and their medical staffs. Even in countries where general practice and hospital practice have developed separately, there is evidence that the truce between them is uneasy and that their traditional separatism needs to be renegotiated.

Upon analysis the problem turns out to be a hydra. It is far more complex than it appears to be to the colleges of specialists, who have barricaded themselves behind operating room and other closed hospital doors on the premise that, if they can keep the family doctor out, everything will be lovely. There are issues of political control masquerading as quality of patient care, medico-legal issues disguised as professional qualifications and economic wolves in the sheepskins of guardians of the public safety.

Nothing could be more anachronistic or less in the public interest in the 1980s than a series of interprofessional, medieval guild wars designed to protect the purity and sanctity of the modern hospital from the ravages of general practitioner barbarians. The hospital as castle or abbey is indefensible in the face of the public's need for integrated medical care. Hospital doctors are the most heavily subsidized professionals in the world; they furnish neither capital nor employees, nor do they pay the costs of hospital operations, yet they seem to think of themselves as a self-made élite, deserving an unlimited supply of patients from God knows whence, who will disappear after a 6·5-day stay to God knows where.

Most people do not spend most of their lives in hospitals, and when they have to go there it is a temporary event. They have a history and they hope to have a future, in both of which family doctors are likely to have been or will be involved. It makes no sense to exclude general practitioners from the events that occur during the hospital care of their patients. This is not an argument against delineating privileges for hospital medical staff, but it is against the mindless use of procedures that do not recognize the reality of degrees of proficiency and competence. It is also opposed to closed committees which confer hospital staff membership and establish privileges, and to shortages of training opportunities for all staff to upgrade and expand their technical skills. Hospitals are among the last institutions in modern society where one's ordinary rights can be violated, almost with impunity.

Hospitals would do well to consider the benefits that could accrue to patients from having a large and active department of general practice on a par with other clinical departments. Who is better qualified to participate in policy, planning and staffing decisions? Who is in a better position than the family doctor to aid the hospital in professional liability risk management? Who is better able to help in patient admissions, to co-ordinate patient care in hospital and to plan for post-hospital care? A hospital without general practitioners has to depend almost entirely on staff personnel for many of these tasks.

Hospitals are also important institutions for continuing medical education, both formal and informal. Society would be well advised to consider the consequences of excluding large numbers of its doctors from the educational environment of the hospital. When general/family practitioners have no role or responsibility for hospital patients, it is unlikely that they will participate in the hospital's continuing education programmes, and even more unlikely that the hospital doctors would know what or how to teach them. The contributions that the general/family practitioner could make to continuing education would also be lost.

In summary, one of the critical issues in the insti-

tutionalization of general practice in the 1980s turns on the ability of hospitals to abandon their hostility to family doctors.

The business-industrial model of practice

Closely related to the problem of hospitals and doctors is the larger issue of the application of a business-industrial model of practice to the delivery of medical care services. In the USA at least, we seem to be headed for an era of competition among medical care corporations in an attempt to control costs. The national mood does not now seem to favour a totally nationalized health care system, and our experience with limited nationalized programmes, such as Medicare, Medicaid and renal transplantation, does not give much hope of cost control. At the same time we are reluctant to ration medical care, even though many of our leaders have been saying for years that some type of rationing is inevitable and that we simply cannot provide everything for everybody.

Our interim solution to these problems is to make a virtue of our system of public and private care by forming large numbers of health care corporations, consisting of doctors and hospitals, which will be able to bid for groups of patients on a prepaid basis. This is attractive to businesses and even to labour unions. There are a number of such corporations now in existence; the Kaiser Plans are the best-known prototypes.

The place of family doctors in such corporations is unclear. They have not found much of a role in multiple specialty clinics, but there seems to be no compelling reason why a role could not be developed. The business–industrial model takes as its symbol the assembly line. What is required for the assembly line is the fragmentation, delegation and the hierarchical ordering of tasks; there must also be a definable product by which the entire operation can be judged and measured. Medicine has always lacked such a definable end product. In fact its 'product', as in education, is a service. However, our experience with public education in this country is discouraging as an example of the application of the business model to a service industry. Daniel Callahan (1962) has chronicled the 40-year effort to industrialize education in the USA. What we learn from him is that the motto, "The best education for the lowest cost" resulted in a preoccupation with "the lowest cost" to the detriment of "the best education". Cost at least can be measured.

The theologian, Harvey Cox (1973), observed that superspecialization in any field requires bureaucratization. Important though their services are, superspecialists simply cannot be allowed to function autonomously. They cannot be trusted to control the allocation of resources to their specialty nor to determine how and to what extent their services are to be used. The Manhattan Project of the 1940s is a good example of Cox's argument. Superspecialists could and did create the atom bomb, but the decision to allocate resources to the project was made by politicians who were not superspecialists and, more important, the decision, right or wrong, to use the bomb was made by a non-specialist, President Harry S. Truman. One can imagine that if national health policies were now in the hands of cardiac surgeons, we might be developing the capacity to perform 500,000 coronary bypasses annually. The public has a broader stake in health services than that. We also have the example in the USA of recently having spent over 10 billion dollars on cancer research without a great deal to show for it. What reason do we have for believing that another 10 billion would produce a different outcome?

In the medical corporations that we know about, the general practitioner's role is usually somewhere near the front door of the corporation triaging the patients and in some cases regulating the use of services. These are low level tasks and are rewarded accordingly. By and large both tasks are objectionable for reasons that will be described below.

It seems clear that if a medical corporation is going to succeed, it should not be top heavy with superspecialists. On the contrary, there should be relatively larger numbers of general practitioners who provide a range of outpatient and domiciliary health services and who are rewarded appropriately for these services. The great gap in income between surgical and non-surgical specialties must be narrowed by reducing the unit cost of all surgical and technical services. The day must pass when a doctor can earn more for incising and draining an abscess or removing a foreign body than for spending an hour counselling or teaching patients. Until we improve the communication skills of doctors and justify spending more time with patients, we will know very little about preventive medicine. Time spent with a pregnant woman educating her about caring for herself and her expected child has a better chance of reducing the medical care cost for that family over the following 10 years than almost anything else I can imagine.

The work of the family doctor

Underlying the institutionalization of general practice is a more fundamental problem, that of identifying the essential characteristics of its clinical work, especially those characteristics that may be considered unique or of special importance. How the work is understood and interpreted goes a long way towards determining what social values are attached to it and how it becomes organized, distributed, accounted for and perpetuated. Is general practice difficult or easy, hard or soft, simple or complex, major or minor, superficial or deep, cheap or expensive? The list of questions can be extended indefinitely, but none of them captures the central one of what happens, or ought to happen, between doctor and patient in general practice. Until we know this we cannot possibly decide whether to encourage family

medicine or allow it to undergo further attrition and possible extinction.

One of the unfortunate aspects of the term 'primary medical care' is that it suggests a division of labour that focuses on the simple, minor, sorting-out aspects of medical care, presumably those aspects which almost anyone could do with a minimum of education and experience and which are not truly gratifying. Primary care is usually seen in contrast to secondary or tertiary care, which are more exciting, demanding, important and fulfilling. All of these terms express assumptions about clinical work that are not ordinarily examined with much clarity or precision.

My purpose in making these observations is not merely to take an opposite point of view or to build a spurious case for the greater importance of primary care. I happen to believe that some of the tasks in primary care, especially those involved in long-term care, have been underestimated; but whether or not this is so, I want to reassert what the American Academy of Family Physicians has been maintaining for years, namely that primary care and family practice are not the same. Family doctors do primary care as part of their work, but so do other doctors and certain staff who are not medically qualified. Family doctors, however, do more than primary care and it is this dimension of their work that I now wish to describe.

Breadth—the universal interest

Perhaps nothing is so misunderstood about the general practitioner's work as its breadth. This misunderstanding usually takes the form of either asserting the impossibility of knowing enough or contempt at knowing a little about many things. The critics are wrong in what they usually take to be the object of the family doctor's knowledge: they assume it to be quantitative information such as might be stored in the National Library of Medicine. If this were the measure of a doctor's knowledge, how could anyone, even the most narrow specialist, ever be content that he or she knew enough? While I suspect that most of us could know a great deal more than we do, and that many of our limitations are arbitrarily imposed, family doctors have never maintained that the breadth of their vocation implied knowing everything about medicine. On the contrary, we have been careful to acknowledge our limitations, yet at the same time to insist that we have a legitimate interest in everything that affects our patients. If this seems paradoxical or contradictory, it is because we are up against the words we use to describe our interests. The words 'comprehensive' and 'whole' are especially troublesome because they imply 'all', 'total' or 'complete', and when general practitioners say that they provide comprehensive health care or are interested in the whole person, critics either smile at their naïvety or rage at their insolence.

Berger and Mohr (1976) in their compelling little book, *A Fortunate Man: the Story of a Country Doctor,* used the term 'universal' to describe the breadth of the doctor-patient interaction:

> "Good general diagnosticians are rare, not because most doctors lack medical knowledge, but because most are incapable of taking in all the possibly relevant facts—emotional, historical, environmental as well as physical. They are searching for specific conditions instead of the truth about a man which may then suggest various conditions. It may be that computers will soon diagnose better than doctors. But the facts fed to the computers will still have to be the result of intimate, individual recognition of the patient."

In this passage the authors are calling attention to the need for the doctor to be willing to notice anything and everything about the patient that may be of clinical significance. The family doctor does not have the option of arbitrarily excluding or censoring the patient's complaints and behaviour because they do not fit the cluster of diseases that the doctor is prepared to deal with. Cox (1973) described superspecialization as an excuse to ignore everything that lies outside the specialism. In a superspecialty system of care no-one is required to know the patient as a whole, whereas one element of 'breadth' is that the doctor takes a universal interest in the patient.

There is, however, a deeper meaning of universal that Berger and Mohr also explain. When a person becomes sick with an unknown illness, he feels uniquely selected by mysterious forces and develops a distorted, fragmented form of self-consciousness that separates him from the regularities of his social connections:

> "The doctor, through his relationship with the invalid and by means of the special intimacy he is allowed, has to compensate for these broken connections and reaffirm the social content of the invalid's aggravated self-consciousness."

This is accomplished through the processes of diagnosis and the recognition of the sufferer as a person. The patient is relieved when the doctor has given the illness a name and feels reaffirmed as a brother rather than a stranger with a strange malady.

> "This can be achieved by the doctor presenting himself to the patient as a comparable man . . . The patient must be given the chance to recognize . . . aspects of himself in the doctor, but in such a way that the doctor seems to be Everyman. This chance is seldom the result of a single exchange, and it may come about more as a result of the general atmosphere than of any special words said . . . it is this which then persuades the patient that he and the doctor and other men are comparable because whatever he says of himself or his fears or his fantasies seem to be at least as familiar to the doctor as to him. He is no longer an exception. He can be recognized. And this is the prerequisite for cure or adaptation."

The doctor carries on this levelling process with many patients at the same time by offering to each what he imagines it must be like to be in the patient's shoes, thereby alleviating the patient's sense of alienation. What the doctor is aiming at is a sense of understanding

and mastery over the universal human condition of which sickness is an integral part.

Therefore when we speak of the breadth of the family doctor's work, we are not speaking of a ratio of what is known compared to what is knowable or what is known by all family doctors collectively. Rather, we are speaking of the willingness and ability to make oneself available to every patient, or, perhaps better, to any patient, to overcome the patient's sense of alienation and depersonalization, no matter what the disease process. Because of our divisions of labour in medicine today, the general practitioner is nearly the only doctor with an opportunity to become the universal man.

Depth—the historical perspective

If the breadth of general practice is understood as a universal interest in whatever may be of clinical importance to a patient, the process by which this interest is served is that of historical investigation. The doctor functions as a professional historian for the patient, both discovering and inventing the patient's clinical biography. Franz Kafka (1952) wrote:

> "To write prescriptions is easy, but to come to an understanding with people is hard."

There is a great deal of misunderstanding and underestimation of this dimension of the general practitioner's work. At one level it appears prosaic, even trivial. All medical students are taught very early to "take their patients' histories" and, generally, doctors become very adept at the game of 20 questions (or in some instances, as in the Minnesota Multiphasic Personality Inventory (MMPI), 700 questions) to elicit from patients the histories of their diseases, at least those diseases of which the doctors have knowledge. This is a necessary, though elementary, skill and one could wish that it were done better than it often is. If it were, one could predict that there would be less overreliance on the clinical laboratory and diagnostic radiology than is the case.

Sigmund Freud was the first to identify the deeper and more pervasive role of the doctor as a historian for the patient. He recognized the importance of the patient's life experiences and fantasies and of the interpretations of those experiences as factors in the generation of illness, not only of psychological illness but of physical illness as well. It is worth acknowledging here that psychoanalysis is the father (or mother, if you prefer) of psychosomatic medicine. Our modern understanding of the interrelationships between mind and body go beyond the theories of psychoanalysis, but we have a primary debt to Freud and his followers.

Adolph Meyer in the 1920s and 30s was among the first American doctors to incorporate a chronological life chart into regular clinical work and he wrote about the necessity of knowing the patient's name. There may be a good deal of clinical work that can be performed by anonymous doctors for anonymous patients, but there is an even greater amount that requires a degree of intimacy with the patient that only the use of his name allows. John Whithorn (1961) wrote about those illnesses produced by man's pathogenicity for himself. Even if we could magically eliminate all known diseases, doctors would be kept busy with the clinical problems that arise out of the ways we treat each other in families, communities and nations.

Do not presume here that I am speaking only of psychological or emotional illnesses and problems. Increasingly it is being documented and acknowledged that all of the major causes of morbidity and death, at their root, are 'psychosomatic', or more accurately, to use George Engel's (1977) term, 'biopsychosocial'. Our knowledge of neuroendocrinology and immunopathology provides a broad, final, common pathway through which a large number of seemingly disparate noxious stimuli express themselves in organic diseases ranging from infections and hypertension to atherosclerosis, degenerative diseases and even cancer. One can assert that there are no purely organic diseases; all are 'organismic', which is only a way of saying that when someone is sick, he is sick all over.

The general practitioner is committed to helping patients understand their illnesses in the light of their personal and family histories, which is very nearly the only way that patients can liberate themselves from pathogenetic patterns of behaviour and circumstances. This indeed requires knowing the patients' names and the experiences, memories and feelings these names stand for. How can this knowledge be acquired? By acknowledging that this is a legitimate and necessary clinical task and by wanting to do it. Such knowledge can never be acquired in a system of episodic medical care in which doctors are instrumental and interchangeable and patients' names are only labels for their diseases.

What is required is a therapeutic relationship between patient and doctor that is not only concerned with taking the patient's history, but which also allows both to meet as real persons, re-enacting various aspects of their personal identities in the hope of healing. The willingness to do this makes demands on the doctor as well as the patient, demands for transparency, honesty, acceptance and refusal to exploit the patient's autonomy. In this relatively safe arena patients can come to recognize and reconsider aspects of their lives that may be contributing to their illnesses and expand or change their range of responses to whatever is making them sick. We do not believe that a patient's history is ever completed or that hope is ever finished. Even when the illness is incurable or fatal, that too is a part of life's history that deserves understanding and succour.

All this is not meant to overdramatize or sentimentalize the work of the family doctor; rather it is to call attention to one of its essential characteristics. Neither is this meant to imply that only family doctors do historical work with their patients. All good clinicians come to realize its importance sooner or later, but general

practitioners have a conscious commitment to practise and teach these skills and to insist that this work be valued appropriately.

Risk—the existential situation

For 300 years there has been a growing schism between the science and the art of medicine. As science has become more powerful and admired, the role of doctor-scientist has come to overshadow that of doctor-artist and the latter has been relegated to a superstitious past that we would all like to forget. I have no intention of resurrecting this debate in its usual form because I believe that the modern general practitioner has to find a way of incorporating both science and art into his or her work. The dilemma of how to do this is never likely to disappear or be resolved because it represents the tension that exists between two forms or perceptions of reality. It is what the theologian Paul Tillich (1966) called a 'boundary situation':

> "When I was asked to give an account of the way my ideas have developed from my life, I thought that the concept of the boundary might be the fitting symbol for the whole of my personal and intellectual development. At almost every point I have had to stand between alternative possibilities of existence, to be completely at home in neither and to take no definitive stand against either. Since thinking presupposed receptiveness to new possibilities, this position is fruitful for thought; but it is difficult and dangerous in life, which again and again demands decisions and thus the exclusion of alternatives. This disposition and its tension have determined both my destiny and my work."

Tillich's 'boundary' is an apt metaphor for much of the work of general practice, which by necessity takes place amidst the ambiguity and uncertainty of people's lives and requires decisions that often go beyond the answers provided by science. Medicine is always practised within the context of values, beliefs and rewards that are not the products of science but derive from culture.

The old country doctor in Kafka's strange and mysterious tale expressed the dilemma for all of us. On a night call in a blizzard to the home of a boy with a worm-infested wound in his side, he was asked the universal question, "Will you save me?".

> " 'That is what people are like in my district,' he reflected, 'always expecting the impossible from the doctor. They have lost their ancient beliefs; the parson sits at home and unravels his vestments, one after another; but the doctor is supposed to be omnipotent with his merciful surgeon's hand. Well, as it pleases them; I have not thrust my services on them; if they misuse me for sacred ends, I let that happen to me too . . .' " (Kafka, 1952).

Another fictional doctor described another aspect of the boundary in Camus' tale of the plague in a city in Algeria in the 1940s. When the fatal epidemic was first being recognized by the doctor, the narrator observed this about the community:

> "In this respect our townsfolk were like everybody else, wrapped up in themselves; in other words they were humanists; they disbelieved in pestilences. A pestilence isn't a thing made to man's measure; therefore we tell ourselves that pestilence is a mere bogey of the mind, a bad dream that will pass away. But it doesn't always pass away and, from one bad dream to another, it is men who pass away, and the humanists first of all because they haven't taken their precautions. Our townsfolk were not more to blame than others, they forgot to be modest—that was all—and thought that everything still was possible for them; which presupposed that pestilences were impossible. They went on doing business, arranged for journeys, and formed views. How should they have given a thought to anything like plague, which rules out any future, cancels journeys, silences the exchange of views? They fancied themselves free, and no one will ever be free so long as there are pestilences" (Camus, 1960).

These writers are describing the conditions under which all medicine is practised, even in modern times—conditions that are disorderly, superstitious, unrealistic and misinformed, conditions governed both by chance and necessity and in which evil is a reality. It is simply not possible, or even desirable, for doctors to impose a pure science of medicine on such conditions. Even if science had all the answers, which it does not, compromise with the realities of life is inevitable. So the practice of medicine is existential, that is to say decisions must be made in the face of uncertainty and the power of science must be exercised and administered by men and women who are fallible and weak on behalf of suffering people who are also fallible and weak. The greatest outrages occur when these facts are not acknowledged, and medicine is at its cruellest when it encourages or allows the public to believe in its dogmatic omnipotence. Humility has always been the hallmark of the greatest doctors and it is our only defence against the exploitation of our patients.

Because general practice occurs in the community, closest to the people's natural and ordinary lives, it must be especially sensitive to its 'boundary-fate' (Tillich's term) and not pretend to be above or beyond the ambiguities of this circumstance. In concluding this section I wish to mention three boundaries that have special significance now.

1. Definitions of sickness. The first is the boundary between sickness and non-sickness. Several writers have called attention to our modern tendency to define all human trouble as sickness. As long ago as 1787 Goethe predicted that the world would become one huge hospital "where everybody is everybody else's humane nurse". More recent writers have described the 'medicalization' of society, a process by which more and more human behaviour is defined as a medical problem. First it was alcoholism, then delinquency, now obesity and unhappiness. The disease model, even the biopsychosocial model, cannot be used to explain everything that goes wrong.

When the Jonestown mass murder/suicide was discovered by an incredulous world in November 1978, the only thing that reporters and newscasters could offer by

way of explanation was that the Rev. Jim Jones must have been sick! Think about that—an atrocity of inhuman proportions as a medical problem!

When Dan White, who murdered the mayor and city supervisor of San Francisco in December 1978, was tried he pleaded not guilty on account of "diminished responsibility", which his lawyers blamed on abnormal brain function due to a heavy diet of Coca-Cola, cupcakes and Twinkies, the so-called 'Twinkie defence'. So we now have a political assassination as a medical problem!

We have simply got to stop using sickness as our only rationale for whatever happens. Absurdity, evil and irrationality are still with us as part of the human legacy of experience and we cannot expect that science, especially medical science, is the antidote to these. There is a boundary between sickness and non-sickness.

2. Attitudes towards death. The second boundary of modern importance is that between life and death. This is not the time or place to try to discuss this boundary in detail but humanity is not well served by our failure to realize that death is a natural phenomenon and is not to be resisted at all costs and by any means. Kierkegaard was aware of this dilemma:

> ". . . the torment of despair is precisely this, not to be able to die . . . When death is the greatest danger, one hopes for life; but when one becomes acquainted with an even more dreadful danger, one hopes for death. So when the danger is so great that death has become one's hope, despair is the disconsolateness of not being able to die" (Kierkegaard, 1954).

There are fates worse than death and medical practice deals with this boundary continually. Part of the work of family doctors is to help their patients make decisions about the time and circumstances of death.

3. Dependence on technology. The third boundary is that between dependence and autonomy; it is basic to the others. Doctors cannot afford to delude themselves or their patients in the belief that all problems have a technological solution and that, if patients will only submit themselves to the authority of medicine, they will be safe and sound. There is a boundary between the appropriate support of the weak, infirm and disabled and the addiction to medical care. It is clear that health comes less from the work of doctors than from the self-responsibility of people. We have an obligation to free our patients from the inordinate dependency on drugs and surgery that characterizes so much of modern medical practice. We will never promote health by means of curative medicine and the sooner the public learns this lesson, the better off they will be. The family doctor walks this delicate and narrow boundary.

In summary, the work of the general practitioner is universal, historical and existential, in addition to being appropriately technological. It is essential work that must be done if medicine is to meet the clinical needs of modern people.

Conclusion

The rebirth of general practice is a unique phenomenon. John Knowles once suggested that it is the equivalent of the Flexnerian reform for the latter half of the twentieth century. It is too early to say whether it represents a real turn in the history of medicine or whether it is merely a deflection in medicine's trajectory that will soon be corrected by the prevailing powers.

I suspect that part of the answer to these questions lies within those who are advocates of reform. Will we splinter ourselves into conflicting special interest groups? Will we become embroiled in battles over leadership and political rule, putting our own interests at a higher priority than the needs that have called us into existence? In short, will we recapitulate the ontogeny of medicine as a whole? If we do, we can be sure that the public will find some other way to meet its needs.

Medicine is and ought to be a servant profession, calling into its ranks people who are committed to a moral discipline, who believe that altruism and public service are not merely vestigial remnants of a nostalgic and ignorant history. The ghosts of Wilfred Grenfell, David Livingstone, Albert Schweitzer and Thomas Dooley call us to remember that general practitioners have been some of medicine's finest heroes and that medicine serves itself best when it serves the public most. May we all find our personal way in sharing that vision.

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