"The stories of the ghosts in our building are still told. The hospital where I used to do a clinic had very few patients attend because of the (incorrect) rumour that it used to be a morgue."

A practice of place

My medical degrees aren't just qualifications, they are passports. It wasn't long after I became a doctor that I came to Australia for the first time, and then again after my GP training. I've done quite a lot of moving around, never spending more than about 3 years in one place. Except now, I'm coming up to 14 years in one practice. I'm not unusual. Many doctors in both Australia and in the UK aren't working in the country in which they qualified. In the EU, doctors are among the most mobile professions[1] (with ski-instructors being the most mobile!).

Clearly, we've got transferable skills. Taking a history and exam is similar wherever we are, and, although health systems and funding are different, they still tend to be modelled around the convenience of clinicians, no matter how frustrating we might find the bureaucracies. The definitions of general practice adopted by WONCA Europe (including the RCGP) and by the Royal Australian College of GPs are consistent in what we might regard the universal principles of general practice — patient-centred, relationship-based care, the first port of call for all symptoms and the management of disease, complexity, and uncertainty at all stages of life.

I paraphrase a little.

The words context and community pop up in the WONCA definition too, which alludes to a crucial missing element in these descriptions of the work we do — a sense of place. Working in Aboriginal and Torres Strait Islander health has taught me the importance of this. Australia is made up of many different Aboriginal countries (it's worth googling the map of Aboriginal Australia) and it's traditional and respectful to acknowledge the traditional owners of the land that you are meeting on. Rural and remote doctors in Australia have a saying that once you've seen one country town you've seen one country town. As you settle in a place you get to know its geography and its history — its stories. Where I work, the history of the local massacre still matters and is still commemorated. The stories of the ghosts in our building are still told. The hospital where I used to do a clinic had very few patients attend because of the (incorrect) rumour that it used to be a morgue. Everywhere has these stories — the practice that used to be the bowling club, the place that the police patrol, the people being moved because their houses are being pulled down and rebuilt. Everywhere the stories are specific. We can't guess them from elsewhere, and they don't make as much sense without the local geography and history. But this local knowledge — perhaps hyper-local knowledge — is the context that is important for our work. It doesn't come instantly, and travelling doctors outside of their normal area can only touch the surface of this at best.

Why is this important? Without acknowledging that GPs are doctors of place as well as of people, we — and perhaps more importantly, those who are organising the systems we work in — assume we can drop GPs into unfamiliar communities almost at random without affecting our work. Relationship-based care doesn't work like this, but neither does place-based care. People are still often wary of outsiders.

I'm not suggesting doctors shouldn't move around — the distribution of doctors clearly follows the inverse care law after all — but we should do our best to get to know the place we work as well as the people. Perhaps we should think of our qualifications as permanent residencies, rather than passports.

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