General practice and the inherent dignity of the individual

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'YOU NEED TO KNOW SO MUCH!' is usually the first remark medical students make after a morning of observing clinic consultations. They are quite right. If a medical practitioner is to care for the whole person across their lifespan, they must have expertise in patient care across organ systems, treatment modalities and demographics. The student usually shifts into disclosing empathetic reflections on a patient encounter. These beginnings will mature over their training years into significant insight. They will say something like 'I hope Mr Trevor finds his dog. Is he right it caused his cough? Does walking in the rain really bring on asthma? It's so sad about his partner.'

Generalism asserts that the individual has inherent dignity and is more than the sum of their body parts.[1] Although some textbooks and research are by necessity disease-centred, they do not reflect the experiences of most people in the community. The highest standard of health is more than treating a person's presenting symptoms. It follows that the skills and resources needed to understand and manage cardiovascular disease, a febrile child or skin disease in the community are different to other settings.

The dignity and equality of all persons produces three practical applications – narrative, patient outcomes and influence – for general practice.

General practice focuses on narrative. The paradigm of the story is well-suited to the complex, absorbing real-life events of sickness and death. Every consultation opens with a story. The patient and GP co-create the next chapter, and in time the patient–doctor relationship. Diagnostic and therapeutic clarity requires careful attention, skill in linguistics and interpretation, and openness to considerations that clinical medicine cannot answer well. Outside of emergencies, people exercise a level of agency in who they consult, and what of themselves they disclose. This ought to influence system design. A good example of systematically applying narrative is that of the GP's approach to men's sexual and reproductive health clinics, described by Duns, Temple-Smith and Katz, which attempts to lower barriers to healthcare.[2]

GPs put good patient outcomes in the centre when applying their biomedical knowledge. The sophisticated paper by Lynch, Thomas, Askew and Sturman uses the phrase 'the generalist gaze' to conceptualise the integrative scope of practice when responding to patients in distress.[3] Tseris argues the strengths of a feminist lens in day-to-day practice for women with mental health concerns seeking healthcare.[4]

General practice is conscious of its influence as an institution in society and healthcare. GPs as cultural members in medicine share a set of social facts about sex and gender, age, economic status and cultures. Our interests affect our evidence base. Medical biases and tendencies do not serve all our patients equally. Aquino warns how uncritically applied artificial intelligence-enabled technology amplifies and even creates new categories for discrimination.[5] Diversity in medicine is one way forward. Who and how we train enhances the profession's knowledge of the same health event in different ways. The skilled supervisor, as powerfully articulated by Milroy and Bandler in Indigenous health medical education, judiciously analyses assumptions that frame commonplace interactions to support the registrar to develop their own approach.[6]

Any complex system, like the human body, is continually sensing and adapting to changes over time through feedback loops. In the healthcare field, some loops distort and diminish our shared humanity.[7] As a profession, may our struggle together always be to respond primarily to human need.

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