Brave new world: a reflection on the life's work of John Fry and its link to General Practice in the 21st century

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When Aldous Huxley first described his vision of a 'brave new world'¹ few of his readers would have recognized the chilling society he presented. It is likely that were John Fry to visit the contemporary world of general practice he too would be taken aback by the transformed context in which we care for patients and the different frameworks within which we work. However, for all the changes witnessed, much of the heart of general practice remains the same.

Undoubtedly, Fry's greatest contribution has been his systematic approach to general practice, which in turn has contributed to its evolution as a discipline. Through his rigorous collection of data and analysis of daily practice he captured what was both familiar but, at that time, undocumented. Pickles, as a primary care epidemiologist, was a similar seminal figure in contributing to the scientific basis of general practice. By remaining grounded in the reality of seeing patients, the theory they espoused remained rooted in practice and as such they might be seen as knowledge brokers² in today's terms.

The traditional view of general practice, personified in John Fry, is of a GP following patients from cradle to grave with continuity of care as the norm. Practising in this manner demanded a selflessness which offered quality care for patients but which exacted a toll on the doctor's quality of life both physically and emotionally. It was not uncommon for GPs to reach retirement in poor health and with dysfunctional family relationships. Consultations also looked different. The fictional image of Dr Finlay belies the reality of five minute consultations, often delivered in public as the GP rotated around the waiting room, prescription pad in hand.

The power and authority accorded to GPs has also been questioned with a series of flagrant abuses of professional autonomy receiving extensive media coverage. The potential vulnerability of patients was most dramatically exposed by the frankly pathological behaviour of Shipman, although he was a unique exception. The flip-side is the rise of patient empowerment and demise of paternalism which is known to have adverse effects on patient's health, whilst enablement can improve outcomes of health.³

With regard to treatment options, medicine has changed immeasurably.

Despite our contemporary frustrations, we can now offer so much more through an increasing range of therapeutic options. And yet we also practice in a climate of constrained resources, forcing clinicians to make uncomfortable decisions about rationing. To this we must add the increasing panoply of technological interventions which are now available, some of which were previously unimagined, such as face transplants, which bring with them their own set of ethical dilemmas.

Looking more specifically at the changed face of general practice it is perhaps the demographic changes amongst practitioners which are most striking. The feminization of medicine has been a gradual phenomenon, not without its critics,⁴ and there is evidence to support the observation of gendered differences to practice.⁵ We have also seen a greater diversity of ethnicity largely represented by GPs from India and Pakistan who arrived in the 1960s to support a struggling NHS.⁶ Increasing diversity of doctors has also been mirrored by a greater diversity of patients with few practices retaining a homogeneous practice population.

Society has indeed changed beyond recognition; from the traditional, hierarchical post-WWII society of the 1950s to the global, digital 21st century. Social movements from the 1960s such as feminism, anti-racism and patient empowerment have shifted the balance of power in society. The philosophical framework which defines these seismic changes lies within Postmodernism, which views the notion of an absolute truth as problematic, and recognizes that there are multiple truths depending on a person's life experiences. Postmodernism sees the world and social phenomena as social constructions and rejects the positivist approach which frames biomedicine. Out of the maelstrom which gave rise to Postmodernism we have also seen Complexity Theory,⁷ which attempts to explain the inter-relatedness of the complex behavioural patterns we see around us everyday, both in the consulting room and the social worlds we inhabit. Encouraging a questioning approach to practice maintains a tradition begun by Fry and Pickles.

Globalization has changed all our boundaries. Whilst Fry valued an international perspective in his work for the World Health Organization, it is unlikely that our

predecessors anticipated the magnitude of global interconnectedness we are now experiencing. We recognize that national boundaries are permeable with regard to the movement of pathogens and people as we witness the spread of AIDS and the migration of refugees from far-flung countries destroyed by war. Our patient registers now include people whose countries of origin extend from Romania to Rwanda.

And yet, despite the changes to the outward appearance of general practice, there is much that remains the same. Just as in Fry's time, patients, regardless of their background, visit their GP in times of distress and discomfort. They want their GP to be attentive to their needs and offer responses which make sense to them and bring relief. Focusing on the patient's story offers us our greatest chance of offering a useful response, while considering the patient in the context of their family. New models of old wisdom, sometimes known as narrative-based primary care, were inspired by family therapy.⁸ They aim to present a coherent framework which is rooted in the stories patients bring. In addition, common chronic conditions continue to form the staples of daily practice. Fry's book 'The catarrhal child' demonstrates his close attention to those unglamorous but persisting conditions which can blight patient's lives and frustrate doctors.

Farmer, an inspiring physician and anthropologist, describes the 'warmth of clinical exchanges' between doctor and patient as the 'vitality of practice'.⁹ I conclude

with an assertion that despite the enormous changes both within and outside of medicine it is this richness of clinical consulting, coupled with a rigorous questioning approach, which retains our link between the practice of John Fry and those of us continuing in his tradition today, in what remains a challenging but immensely rewarding endeavour.

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