

Perceptual capacity and the good GP: invisible, yet indispensable for quality of care

INTRODUCTION

In his UK survey in 1950,¹ Collings said that general practice, 'is accepted as being something specific, without anyone knowing what it really is.' One might have hoped that over 50 years later, we would be clearer about the specifics of what general practice is or is not. However, this is not the case. Much activity in general practice is dictated by the new General Medical services (GMS) contract.² At the heart of this is a Quality and Outcomes Framework centred on population targets and founded on evidence-based medicine. This provides financial incentives to raise standards of care for the practice population. However, it has been criticised for being poorly attuned to the needs of the individual, and for concentrating on the disease, not the patient.^{3,4} There is also a growing focus on the importance of the narrative in general practice,⁵ which focuses on the individual patient rather than the disease.

It is therefore not surprising that many GPs now find it difficult to understand what a GP is meant to do, or indeed to be. In this paper we suggest that it is only through an approach which focuses on the perceptual capacity of the GP that we can adequately make good decisions with, or for, individual patients (Box 1). It follows that the development of this capacity should also be an important

focus for GP training. This approach is an example of the development of virtue ethics in the field of professional roles over the past few years.^{6,7}

GENERAL PRACTICE AND PERCEPTUAL CAPACITY: THE ELEMENTS

*'... the account of particular cases is yet more lacking in exactness; for they do not fall under any art or precept, but the agents themselves must in each case consider what is appropriate to the occasion ...'*⁸

*'The closer we are to a person, the more we are aware of their individual particulars, and the more difficult it is to think of them as members of a class.'*⁹

The central problem of decision making in general practice is the need 'to sort the unsorted'.¹⁰ GPs deal with a huge range of conditions: the management of ingrowing toenails, the assessment of suicide risk in a depressed patient, the immediate care of meningococcal meningitis are examples of the extremes. Our approach suggests that good GPs develop and foster a refined 'perceptual capacity',¹¹ which enables the possessor to judge properly in each clinical

situation. This is derived from Aristotle's idea of *phronesis* or practical wisdom,⁸ and requires not only an intellectual grasp of the situation, but also imagination and an appropriate degree of emotional engagement (Box 1). We argue that this aspect of decision-making is currently given insufficient weight in current thinking about general practice.

What is distinctive about virtue ethics? It begins with the question 'What kind of person should I be?', rather than 'What ought I to do?' A virtuous person will know what ought to be done in particular situations. Given this, it is natural to focus on what the virtuous person can do — what abilities and capacities does the virtuous person possess that enable (ethically) good judgement? This question is not about what is (ethically) right, but about what enables one to make judgements that are right.

Most 'virtue-style' approaches are based on Aristotle's *Nicomachean Ethics*,⁸ and many focus on the character and the nature of the virtues. However, on our reading of Aristotle, the exercise of virtue depends on practical reason and judgement:

*'... the temperate man craves for the things he ought, as he ought, and when he ought; and this is what rational principle directs.'*⁸

Perceptual capacity is central to this. It is described by McDowell thus:

*'A kind person can be relied on to behave kindly when that is what the situation requires. Moreover, his reliably kind behaviour is not the outcome of a blind, non-rational habit or instinct ... A kind person has a reliable sensitivity to a certain sort of requirement that situations impose on behaviour. ... The sensitivity is, we might say, a sort of perceptual capacity.'*¹¹

Box 1. Some definitions

- ▶ Practical wisdom
The virtue of 'being able to deliberate well'. 'The man who is without qualification good at deliberating is the man who is capable of aiming in accordance with calculation at the best for man of things attainable by action.'¹⁰
- ▶ Perceptual capacity
One aspect of practical reasoning. It comprises an intellectual grasp of a situation, and also embraces the use of imagination and an appropriate degree of emotional engagement.
- ▶ Virtue ethics
A theory of ethics which centres on the claim that the right thing to do is that which the virtuous person would do in a given situation. Typically, the virtues are understood to be particularly valuable and worthwhile character-traits of human agents and are often grounded in an account of what it is to flourish as a human being.

It is this perceptual capacity, aided and influenced by reflection and deliberation, that enables the virtuous person to recognise and respond to the requirements of particular situations. This enables such a person to recognise, read or interpret situations well,¹² and thus to determine what ought to be done.

So, how can this approach help with ethical decision-making in general practice? The answer comes in two parts. First, and in practical terms, this account suggests that we develop and encourage what we might call 'moral seriousness.' In line with its Aristotelian roots, this approach places a significant emphasis on education, reflection and experience. One develops the requisite perceptual capacity precisely through some combination of these activities. Education, reflection and experience prepare the agent for such decision-making and each require, in the end, that the agent take seriously the business of ethics. Ethics (as a discipline) provides a distinctive kind of practical education about the patterns and forms of moral argumentation and justification.

A second way in which the account outlined above can be applied to general practice is by explaining and synthesising the various elements of the clinical encounter. What follows below is a sketch of how such a synthesis could proceed. The various components or aspects of general practice discussed below — evidence, narrative, imagination and emotional engagement — both explain the way that a special perception or sensitivity works and make a case for its plausibility. It achieves the latter by illustrating the way in which the account can accommodate these features.

EVIDENCE AND NARRATIVE

In the course of any clinical encounter, we acquire a large amount of undifferentiated information about the situation — physical findings, perhaps laboratory

results, as well as the patient's experience often expressed as something like a narrative. All of this information requires interpretation.

Some of the information may clearly be labelled as evidence. This may include physical findings and measurements of a patient's cholesterol, blood pressure, glucose, blood counts or other parameters that may be understood through measurement. These measurements are likely to be of considerable significance in decision making. This empirical evidence may well help to specify what will achieve the best outcome for that patient. When Sackett¹³ talks of 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients', he is suggesting strongly that when evidence is available, its consideration should constitute an important part of the process of deliberative specification for that patient.¹⁴ The evidence needs to be appropriately used, and the facts emphatically do not always tell you what to do. Simply and only going on the evidence to determine what is best for an individual patient is naïve, unrealistic and unethical.

The interpretation of the narrative, being concerned with the particular case, must also play a part in the considerations of the GP, and in some cases, it may play a more central part than the evidence. Giving weight to the concerns and values that are often caught up in the stories that patients tell, the accounts of their lives and their illnesses is an obvious way of respecting the patient's autonomy. It is through the patient's story that we understand how they view the situation and what they wish to be done.

The relative weight attached to the elements of evidence and narrative is clearly a matter of judgement in each particular situation. Neither is to be

generally privileged over the other, nor do they exhaust the considerations that may be involved. To think otherwise is to make an ethical and a clinical mistake.

IMAGINATION

Imagination is a term rarely used in medicine today. In our view, it enables the GP to look at what is happening during an encounter in the light of previous similar consultations with this and other patients. It also includes the ability to imagine what the patients are experiencing. Nussbaum¹⁵ describes this as, 'the ability to link several imaginings or perceptions together.' It is not merely memory, as it involves a degree of discrimination, enabling the selection of which remembered items are of importance, and of how much importance.

This is especially important in assessing and responding to changing patterns and new diseases. If we look at a patient and see, among the diagnostic possibilities, only conditions that we have seen before, we risk missing the new disease or the unusual, unexpected presentation. The appearance of many completely new diseases over the past 30 years (for example, HIV, *Escherichia coli* O157, new variant Creutzfeldt–Jacob disease and Severe Acute Respiratory Syndrome) illustrates this very well. We need an imaginative flexibility of response, based on keen observation of what is before us, not pre-interpreted through a rigid framework of thinking only about what has been.

Imagination also enables us to envisage the possible outcomes of differing courses of action, based on our experience of what has gone well and what has gone badly. In Nussbaum's view,¹⁵ imagining is necessarily concrete. It therefore lends itself particularly well to the understanding of complex, multifaceted, ill-defined situations that occur every day in general practice.

EMOTIONAL ENGAGEMENT

Greenhalgh and Hurwitz⁵ suggest pessimistically that:

*'modern medicine lacks a metric for existential qualities like inner hurt, despair, hope, grief and moral pain which frequently accompany and indeed often constitute the illnesses from which people suffer.'*⁵

This is a problem in general practice because we fail to give a sufficiently large place for the perceptual capacity of the doctor. It is only through this that the qualities in question (of inner hurt, loss, grief etc) can be recognised and given a proper place. They first need to be recognised as important elements of a situation by the GP. A response that is appropriate for patient and doctor then has to be determined. There is no 'metric' for this; the right response is the one that fits the situation. In many consultations, a degree of emotional engagement is both necessary and appropriate. Its importance can be seen by considering what happens when it is absent: the problem of 'burn out' among GPs, and the resultant depersonalisation of the patient.¹⁶ The patient is treated not as an individual with worries and concerns about illness, but merely as an example of a disease state. This sometimes happens because, after long exposure to the needs of individuals, the doctor feels the need to protect themselves from the emotional consequences of the patient's distress.

An excess of emotional response can obviously interfere with a proper understanding of a clinical encounter as much as a deficiency. In other words, the right amount of emotional response is required, neither too little nor too much. Emotional awareness, in perceptual capacity, is complementary to intellectual appreciation. Neither is privileged; both are necessary. Aristotle suggests that having feelings:

*'at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way, is what is intermediate and best, and this is characteristic of virtue.'*⁷⁸

Subsequent writers have used different language to suit the times and the discipline, but added little to the original insights. Balint first opened up this area in general practice in the 1950s.¹⁷ McWhinney⁹ makes the point that experience, of great importance in making judgements, 'engages our feelings as well as our intellect.' Nussbaum¹⁵ suggests this means, 'feel(ing) the appropriate emotions about what he or she chooses'.

This area is finally being scientifically investigated. Recent work in the area of neurobiology using positron-emission tomography has begun to demonstrate the neurological basis of emotional responses,¹⁸ and their considerable importance in human relationships and in achieving a humane society. In the field of general practice, Mercer *et al*,¹⁹ using quantitative research methodology, have developed a score for measuring relational empathy, the CARE (Consultation And Relational Empathy) score. They describe relational empathy as 'a complex, multidimensional concept that has moral, cognitive, emotive and behavioural components.' This is a

hugely promising area of development for the future of general practice. Again, however, we should be wary of the tendency to over quantify and over calibrate. What is important is that the emotional response of GPs is given its rightful place, not that it becomes yet another aspect of care to be quantified and measured.

In summary, the emotions enable the GP to focus his or her work. Nussbaum¹⁵ describes the emotions as, 'modes of vision, or recognition', and as an important part of knowing a situation. They are emphatically not primitive forces, but should be used by the GP to guide his responses to a particular situation to achieve the best outcome for the patient.

CONCLUSION

The elements sketched above suggest the centrality of the GP's perceptual capacity in assessing all the elements of a clinical situation^{12,20} (Box 2). With the development of a Quality Framework in the new GMS contract focused on the management of diseases rather than on the individual patient, and a concurrent focus on the importance of the narrative, this approach becomes arguably even more important in ensuring that the right thing is done. It allows the GP to look at both evidence and narrative, but privilege neither. We would argue that only by

Box 2. Summary

- ▶ Evidence-based medicine, the new GMS contract and narrative-based medicine have changed the face of UK general practice radically over the past few years.
- ▶ GPs are uncertain about their role, especially about the effect of these changes on their consultations with patients.
- ▶ Focusing on perceptual capacity provides an approach that allows for all aspects of a clinical situation to be taken into account in making appropriate decisions in consultations with patients.
- ▶ There is a pressing need to assert the importance of perceptual capacity in training and in models of good general practice.

applying such an approach to general practice can we use evidence conscientiously, explicitly and judiciously, as Sackett suggests. Indeed it is these features that are the key: the elements of good judgement.

There are close parallels between perceptual capacity and Greenhalgh's description of intuition.²¹ The focus on the particular context, the importance of experience in focusing the attention of the agent on detail, avoiding excessive reliance on rules and algorithms, and the acknowledgement and use of complexity are common to both. Novice practitioners may adhere rigidly to rules; experienced practitioners who use intuition no longer follow rules or guidelines rigidly. Instead, they rely on judgements that they themselves cannot always explain clearly and rationally, an insight that goes back to Aristotle.⁸ This is reflected in Wiggins' observation that in aisthesis or situational appreciation, 'explanations give out.'¹⁴

Our suggested links to ethics and Greenhalgh's empirical perspective are equivalent here — this is the 'black box' aspect of intuition and the special perceptual capacity. There is here, ineluctably, the relativity of perspective, defensible primarily because there is, in many clinical situations, simply no other satisfactory way forward. In considering many such situations, the fact is that we often understand much more than we can explain, either to others or ourselves. Such tacit knowledge⁹ is of great importance in general practice. It is often invisible, in the sense that when it is present, patients are imperceptibly enabled to understand what is happening to them;²² it is indispensable in that without it, general practice becomes the unthinking application of rules, formulae, guidelines and contractual obligations.

GPs do not need a new account of their role. Instead our account calls for a re-assertion of the primacy of their traditional role; that of listening to and responding

thoughtfully and appropriately to individual patients. This is what a GP is meant to do, and indeed, to be. A particular sensitivity or perception is, we have argued, the key and should be the focus of models of and training for, good general practice.

John Gillies
Mark Sheehan

REFERENCES

- Collings J. General Practice in England Today. *Lancet* 1950; **i**: 555–585.
- NHS Confederation, British Medical Association. *New GMS Contract 2003; investing in general practice*. London, BMA Publishing, 2003.
- Howie J, Heaney D, Maxwell M. Quality, core values and the general practice consultation: issues of definition, measurement and delivery. *Fam Pract* 2004; **21**: 458–468.
- Heath I. 'The cawing of the crow...' *Br J Gen Pract* 2004; **54**: 320–321.
- Greenhalgh T, Hurwitz B (eds.) *Narrative based medicine*. London: BMJ Books, 1998.
- Toon P. *Towards a philosophy of general practice: a study of the virtuous practitioner*. Occasional Paper No. 78. London: Royal College of General Practitioners, 1999.
- Oakley J, Cocking D. *Virtue ethics and professional roles*. Cambridge: Cambridge University Press, 2001.
- Ross D (1953) (translator) Aristotle: The Nicomachean Ethics, Oxford, Oxford University Press. (Oxford World's Classics edition 1953, revised Ackrill J, Urmson J. 1988).
- McWhinney I. The importance of being different. Pickles lecture. *Br J Gen Pract* 1996; **46**: 433–436.
- Purves I. The changing consultation. In: Harrison J, van Zwanenberg T (eds). *GP tomorrow*. Oxford: Radcliffe Medical Press, 2002: 33–47.
- McDowell J. Virtue and reason. In: McDowell J. *Mind, value and reality*. Cambridge: Harvard University Press, 1998: 50–73.
- Sheehan M. Health Care and (a kind of) virtue ethics. In: Hayry M, Takala T, Herissone-Kelly P (eds). *Bioethics and social reality*. Amsterdam/New York: Rodopi, 2005: 149–160.
- Sackett D, Rosenberg W, Muir Gray J, et al. Evidence-based medicine: what it is and what it isn't. *BMJ* 1996; **312**: 71–72.
- Wiggins D. Deliberation and practical reason. In: Wiggins D. *Needs, value truth*. 3rd edn. Oxford: Clarendon Press, 2002: 215–237.
- Nussbaum M. The discernment of perception: an

Aristotelian conception of private and public rationality. In: Sherman N (ed.). *Aristotle's ethics: critical essays*. Lanham: Rowman & Littlefield Publishers Inc, 1999: 145–181.

- Macnaughton J. Arts and humanities in medical education. In: Harrison J, van Zwanenberg T (eds). *GP tomorrow*. Oxford: Radcliffe Medical Press, 2002: 67–77.
- Balint M. *The doctor, his patient and the illness*. London: Pitman Medical, 1964.
- Damasio A. *Looking for Spinoza: joy, sorrow and the feeling brain*. London: Vintage, 2003.
- Mercer S, Maxwell M, Heaney D, Watt G. The Consultation And Relational Empathy (CARE) measure: development of an empathy-based consultation process measure. *Fam Pract* 2004; **21**: 699–705.
- Gillies J. *Getting it right in the consultation. Hippocrates' problem; Aristotle's answer*. Occasional Paper No 86. London: RCGP Publications, 2005.
- Greenhalgh T. Intuition and evidence — uneasy bedfellows? *Br J Gen Pract* 2002; **52**: 395–400.
- Howie J, Heaney D, Maxwell M, et al. Quality at general practice consultations: cross-sectional survey. *BMJ* 1999; **319**: 738–743.