

PERSONAL POINTS OF VIEW

GENERAL OR FAMILY PRACTICE—A SCIENCE?

J. W. BAKER, B.A., B.M., B.Ch., D.Obst.R.C.O.G.

Winterton, Lincs.*

THIS ESSAY ARISES FROM THOUGHTS stimulated by the College of General Practitioners report on vocational training for general practice, and in particular from the appendix to that document, which contains a syllabus to be taught to young general practitioners. The major part of what follows is concerned with theory, for unless practical applications are elaborated from theory, then they are liable to be ill directed and open to criticism. The suggestions I make arise from the conviction that there is a confusion of thought as to what constitutes the discipline of a general practitioner.

A science has been defined as a systematic body of knowledge, and a scientific way of thought as a systematic way of thought. This is a very broad definition, for it includes those things which we frequently consider opposed to science—The Arts. Thus one can have a systematic body of historical knowledge, or linguistic knowledge, or knowledge of Greek and Latin. In this sense a science means an area of study, and the notion of science does not have relation to the subject matter studied, but rather to the method of study, or appreciation, of the subject matter. Thus a Bach prelude can be appreciated scientifically or artistically, as a body of sound constructed in a particular way and capable of analysis, and as a body of sound complete in itself and appealing primarily to the emotions. Thus there is no true discord between art and science; the former is complementary to the latter, and indeed, they may at crucial times be fused, the creative discernment of the scientist being akin to the creative talent of an artist producing his work.

The foregoing may seem an odd way to begin an essay on the teaching of general practice, but it is important to define in general terms what should be taught; if general or family practice is a science, as defined above, then it must have an organized body of knowledge which is peculiar to it and to no other branch of medicine. I will attempt to define this subsequently, and my contention is that this organized body of knowledge, this science, is only now, as the specialities within medicine have advanced so far, beginning to emerge. Immediately following from this I would like to kill one bogey that has held advance in general practice back: this is that the power of the individual doctor to know his own patients and interpret their particular signs and symptoms is his chief asset and cardinal function: it is a very compelling argument, and has a great

*Present address Mbale Hospital, Mbale, Uganda.

deal of truth, but in its essence it inhibits progress, because it prevents the doctor from examining his work scientifically—from producing order out of the myriad of facts with which he is faced daily. It is the artistic approach, as opposed to the scientific approach to general practice. Since all people are different, and most can be known well by one or two doctors only in the course of their lifetime (even this only in areas where the population is static, which are becoming fewer in our increasingly mobile society), this approach means that expertise in general practice can only be acquired with time, haphazardly: that it cannot be taught. If family practice is to survive, then it must advance scientifically.

In reading the study of vocational training in general practice I find I agree with most of the things which are set out. These things should be taught to general practitioners. It is possible that they should be taught by general practitioners, but this is debatable, for it is not necessarily true that those who practice something are the best teachers of it. For example, domiciliary obstetrics is the intelligent application of the *principals* of obstetrics—which is definitely a science—to a particular circumstance. As progress is made in specialities so the techniques arising from this progress are taken over by the general practitioner. It is probably better that the specialist should teach in these fields, leaving the general practitioner to apply this newly learned skill to his own patients in a way that suits them: for a specialist has more difficulty in doing this latter task effectively, because he will not have acquired, during his training, those particular skills which the family practitioner should have acquired, and it is the synthesis of these two sets of skills which makes for the successful treatment of a patient at any one particular time.

From the point of view of those who think that some general practitioners should be teachers, what I have said will appear nihilistic. It arises from the report, which lays emphasis on the application of specialist knowledge to home conditions. Any specialist can tell you in clear anatomical or physiological terms what is the nature of his speciality. An ear, nose and throat man is concerned with diseases of a clear anatomical region—with all sorts of disease within that area. An endocrinologist's field of study is equally clearly defined, though in physiological terms. These things these men can study and teach. What is the area of study peculiar to the general practitioner or family doctor?

The failure of the vocational training report is that it does not define a true area of study, and from this must spring all advance and teaching. This is a pity, because the germ of what should be studied and taught is in fact contained in the syllabus, but is submerged in a mass of irrelevant detail. Many of the headings of the syllabus are in fact derisory: for example—certification in general practice, or the use of the health visitor in general practice. These things should be known about, but they are not essential and are different for different areas of practice. A hospital doctor working for the M.R.C.P. or F.R.C.S. examination should on this basis be studying such subjects as the use of the hospital almoner, or the quickest way to the x-ray department, or how to sidetrack official channels. All these things he must know, and the quicker he knows the better, but

they do not constitute the corpus of knowledge which makes him an expert in his own speciality.

I would like now, perhaps after too much initial meandering, to come to those areas of academic knowledge which are peculiar to general practice, and which should be studied and taught by practitioners.

In medicine as a whole two things can be studied:

1. The occurrence and course of any disease within an individual or within a population.
2. The relationship of the doctor to the patient and of patient to family within a situation of health and disease, and the effect of disease upon these relationships—and *vice versa*.

The first of these two fields is open to any practitioner of medicine, and has been extensively covered by specialists in a systematic way over the last 100 years. There is one area of the field which has not been covered which is peculiarly that of the general practitioner—that of the early diagnosis of disease. This is one of the family doctor's prime responsibilities and is very difficult. Dr Keith Hodgkin has published a book on this, but the subject is to a large extent unexplored. It is perhaps easier to grasp this if I give two examples from my recent experience.

A woman of 50 complained of pain in the maxillary region on two occasions. On both occasions she was tender over the maxillary sinuses and on both occasions she responded quickly to a course of antibiotics. My diagnosis was sinusitis and both she and I were happy. Six months later she developed a right sided ptosis and she was shown to have an aneurysm on the circle of Willis which had clearly been pressing intermittently on cranial nerve V, before affecting cranial nerve III. This was successfully treated, so no harm was done—but the early diagnosis was poor.

The later diagnosis was, of course, easy—though clearly the operation was not. It could be said that this should have been considered in the differential diagnosis of the facial pain, and this is a valid comment: these differential diagnoses should be taught, and are taught, by the neurosurgeon: but what he does not teach, and what nobody teaches, is the frequency of different symptoms and signs within a population, and which serious diseases mimic the less serious in their presentation: he does not teach this because he does not know; I suspect that few except Dr Hodgkin do know, and I am sure that no neurosurgeon would be able to do his work if he investigated all people complaining of headache: the psychological and physical assessment of these people should be carried out by the family doctor. Similarly, I have just admitted a man with florid schizophrenia for specialist treatment. From my notes three years ago I see that then, on one occasion, he complained of tiredness; I noted that he was a little incoherent. I reassured him then that all was well and gave him a placebo mixture (after physical examination): again—early diagnosis was poor. This was in fact my job, this was where I should have dovetailed in neatly with the specialist: I had not been trained for this so I failed in it. This field of early diagnosis is one of our prime concerns, yet it occupies only one line of the syllabus. To enlarge on it a little, I would like to make clear the distinction between early diagnosis and early detection. Diagnosis is a sophisticated process arising

from an accurate elicitation of symptoms and signs and the realization that they form a meaningful pattern. Detection of disease means the process whereby one characteristic sign of a disease is revealed—in mass screening programmes, for instance. This is not the practitioner's primary job, but one which would fall more naturally into the sphere of the medical officer of health.

The second field of study which I mentioned is primarily the field of the family doctor, and is a field which by its nature few other doctors can cover, and which has not in fact been tilled at all. Dr Balint and his co-workers have done some excellent work in the region, but as they point out, there is a vast amount more to be done. This implies that the family doctor must have a considerable interest in and competence in psychological mechanisms, and many people scoff at this. If they do so, then it should be made clear to them that they are in the wrong branch of the profession, and they would be much better finding a niche in a speciality. If general practice is to develop as a field of study and practice of its own, then this it seems is the area which should be covered. If this is done, then it will clearly be seen by the cardiologist that this is not his job, this he does not know about; just as he sees now that he does not know how to use a pair of Kielland's forceps or the indications for their use, and just as the family doctor sees now that the cardiologist's opinion on that cardiac murmur is of more value than his.

If this attitude is adopted, then some of the apparently more boring chores of general practice take on a finer light. The removal of a sebaceous cyst from a man's head takes no great surgical skill, but the conversation which takes place while it is being done can reveal much about himself and his family, and contribute indirectly to his future general health. The same applies to the mother who brings the child with snivelling nose as the presenting symptom of her ill-health: examples could be repeated *ad infinitum*. There must be a balance about this: it may well be that a nurse can deal with many of these trivialities, but all concerned should beware of their psychological implications.

All this leads to a picture of the field of knowledge of the general practitioner. He must be an expert in early diagnosis, he must be very competent in general medicine, especially the acute forms; he must be aware of the traps that beset the diagnosis of acute surgical conditions, though he should not be competent in operative techniques. He should know something of the commoner conditions in each speciality, and be capable of treating them, for if he cannot then his main function—that of observing the effect of disease on the family and *vice versa*—he will not be able to carry out.

There is a third great area of disease which should be taught by the general practitioner, and these are diseases which never see the inside of a hospital: these are numerous, but the infectious diseases of childhood are a classic example.

Such a theoretical consideration of the position must precede a practical assessment of the possibilities in the teaching of general practice. If what I have said is accepted, then the implications are considerable. Firstly, each paragraph is grossly incomplete, and should be enlarged—by many

people. It may be that these comments are superfluous, and reflect only my own lack of knowledge. If so, then although some of the blame lies with me, some must lie with those who only six years ago taught me in medical school, for failing to direct my reading. If the concepts put forward are accepted, even if altered, then the dovetailing of the family doctor with the specialist will be effective, and not as now, too clumsy: each will know his own job. Equally, what I have said will only apply fully in the context of England: clearly a doctor who cannot set a Colles' fracture is a poor doctor 100 miles from specialist help: but equally a doctor who only sees one Colles' every two years would be failing in his duty if he did not ask a specialist five miles away to do so.

I understand that the Vocational Report on General Practice Teaching has been well received in many quarters. I am concerned that as its syllabus stands at present it should not be too well received, for it fails to distinguish what should be taught by specialists to general practitioners, what should be taught by general practitioners to specialists and those whose aspire to be general practitioners, and what should not be taught but quickly acquired. It does not define a corpus of knowledge which is peculiar to general or family practice. Dr Ian McWhinney, in the *Lancet*, defines such a syllabus completely, and effectively, though not in detail.

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THE STRUCTURE OF THE COLLEGE OF GENERAL PRACTITIONERS

A radical view

D. H. IRVINE, M.D.

Ashington, Northumberland

IN THE HISTORY OF THE College few major issues have been more keenly debated than the criteria for admission to membership. The controversy continues despite a tightening of regulations in November, 1964, but