Family medicine—at a loss for words?

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SUMMARY. Family medicine is an emerging discipline, in the process of generating a literature and language of its own. This paper explores the ways in which language can both facilitate and inhibit changes in the way the world is seen and thought about.

'When I use a word' Humpty Dumpty said, in a rather scornful tone, 'it means just what I choose it to mean—neither more nor less.'

'The question is,' said Alice, 'whether you can make words mean so many different things.'

'The question is,' said Humpty Dumpty, 'which is to be master—that's all.'

Lewis Carroll

ALICE, throughout her journeys in Wonderland and Through the Looking Glass, often betrays the irritation and frustration she feels when her comfortable Victorian view of reality is challenged. Not only are the situations she faces outside her previous experience, but she constantly finds that the language she is used to is insufficient to cope with her new surroundings, and indeed sometimes inhibits her understanding of what is happening to her. We talk of being 'at home' in a language, we claim to 'have mastered a language', to have 'been brought up' in a language, to 'have good command of' a language—yet here is Humpty Dumpty suggesting that perhaps sometimes language masters us.

Family physicians seem by nature to be a pragmatic breed. Self-selected individuals who work in surroundings where we are confronted by a limitless range of situations and problems, we often seem to value action more than words, although for few occupational groups are words and language so important yet so ill-understood. When we worked in isolation such pragmatism was perhaps inevitable, but now that we have developed a teaching role, and hence a need for introspection, language is of increasing importance as it affects our understanding of what we see and think, and how we communicate such understanding to students and colleagues.

More particularly, as a group that is beginning to explore and espouse the cause of an expanded medical model that encompasses biomedical, psychological and social factors,[1] we need to know how language may both facilitate and inhibit such a change in outlook. Such knowledge may determine whether indeed we will master our language, and hence our subject, or be mastered by it.

This paper explores how language, both in structure and in use, may influence our view of the world, how we see and think about the problems we encounter, and the way in which we identify and conform with social groups.

Family medicine is certainly not unique in its relationship to language, but as a developing field it serves to point out and highlight the significance of such a relationship.

Language and the world view

'. . . . The thought of the individual must run along its grooves; but these grooves, themselves, are a heritage from individuals who laid them down in an unconscious effort to express their attitudes toward the world. Grammar contains in crystallized form the accumulated and accumulating experience, the Weltanschauung of a people.'

Dorothy D. Lee[2]

Do we live in a language-limited world?

The extent to which the beliefs of a culture influence the basic construction of its language, and conversely the extent to which language limits the view of the world available to a culture remains a topic of debate among linguists. It is a subject of some importance to physicians: if the health beliefs of a culture are related to and enmeshed in the structure of its language, a consequence may be that the language itself then makes it more difficult to express divergent or changing views.

Edward Sapir[3] was one of the first to suggest that we see the world only as our language tells us to see it, and think about the world only as our language allows us to think about it—that each language type, representing as it does a cultural group, views reality in a particular way. He considered that while a particular language may open up perceptual and conceptual vistas in one direction, it may close down other avenues and divergent points of view.

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Contemporary linguists place less value on the link between language, culture and reality than did researchers such as Sapir. It seems to be agreed that languages differ in many strange and striking ways, but it is a moot point whether such differences in language structure are associated with actual differences in ways of perceiving and conceiving the world.[4] The view now is that reality is the same for all people, but that some people segment that reality differently.[5]

Roger Brown,[6] after an extensive review of the subject, concluded that, 'In natural languages . . . vocabulary, inflection and modes of sentence structure . . . do not make it impossible to express certain things, they merely make it more difficult to express them.'

Part of this difficulty is the conservative tendency of language. 'Cultural elements, as more definitely serving the immediate needs of society and entering more clearly into consciousness, will not only change more rapidly than those of language, but the form itself of culture . . . will be constantly shaping itself anew. Linguistic elements, on the other hand, while they may and do readily change in themselves, do not so easily lend themselves to regroupings, owing to the subconscious character of grammatical classification. A grammatical system as such tends to persist indefinitely. In other words, the conservative tendency makes itself felt more profoundly in the formal groundwork of language than in that of culture.'[7]

The underlying metaphysical assumptions of Indo-European languages provide an interesting example of this dilemma. In these languages there seem to be two dominant forms of sentence:[8] the subject-predicate type—for example, 'The book is red'—and the actor-action type—for example, 'John loves Mary'. In the first type there is no action, merely a quality attributed to a subject; in the second the subject is thought of as taking an action. In either case, however, the subject is typically an enduring object, and even when the subject is not an 'object'—when it is a thought or concept—the tendency is to speak of it as if it exists.

In the absence of an actor, a subject—'it'—is invented. Thus 'It rains'. The potential effect, and hence limitation, of such a grammatical construction is that when concepts stand as actors they may become substantive. The concept of 'disease' is an example. Disease as a concept has no concrete reality, rather it represents an organization of thought that stands as an actor. However, as an 'it' the concept may come to be strongly associated with reality.

The substantive use of the disease concept, the idea that diseases are 'its' and hence beyond a patient's control, and the consequent depersonalization of illness are all faults laid frequently at the physician's door—the contemporary outcome of an ontological view of disease that had become dominant by the eighteenth century. However, Eric Cassell,[9] in a study of patients in New York, found that they regularly spoke of symptoms, diseases, and diseased body parts as 'its'—as objects apart from themselves. As a result of his study, Cassell raises the question whether the patient's view of disease has come about because of the prevailing ontological disease concept, and hence is a learned response, or whether this view follows from something deeper in thought.

Is the underlying grammatical construction of our language the reason why biomedicine (full of 'its' like infections, cancers, ulcers, aneurysms which are all 'doing things' consisting of actors and actions) makes immediate linguistic sense, and perhaps why we seem to have trouble with apparently vague processes and influences as represented by the psychological and social factors in our lives?

By way of contrast, Navaho Indians have no trouble in accepting and expressing ideas of health and illness that have to do with harmony and balance; the metaphysic of their culture and the structure of their language allows them to do so with ease.[10,11] Our language, with its actor-action emphasis, makes it more difficult to talk in these terms; it encourages 'its' to stand for influences, and the 'its' can get out of hand and take on a reality of their own. Our language seems to facilitate reductionism and is less kind to a holistic philosophy. It encourages the depersonalization of illness and the placing of disease beyond the patient's control, which is not a point of view conducive to a changing philosophy that wishes to encourage the mutual sharing of responsibility between patient and physician.

This conservative tendency of language may influence the readiness with which different and expanded views of illness are accepted and incorporated by both the culture and the profession within which we live.

Language and vocabulary

> *'What sort of insects do you rejoice in, where* you *come from?' the Gnat inquired.*
>
> *'I don't* rejoice *in insects at all,' Alice explained, 'because I'm rather afraid of them—at least the large kinds. But I can tell you the names of some of them.'*
>
> *'Of course, they answer to their names?' the Gnat remarked carelessly.*
>
> *'I never knew them to do it.'*
>
> *'What's the use of their having names,' the Gnat said, 'if they won't answer to them?'*
>
> *'No use to* them,' *said Alice, 'but it's useful to the people that name them, I suppose. If not, why do things have names at all?'*
>
> Lewis Carroll

If grammatical construction is crystallized and relatively immutable, then the vocabulary of a language is the element that is flexible. Whether or not a culture and its metaphysics does determine the major categories and types that are isolated from the world of phenomena, a significant factor affecting such isolation is the immedi-

ate environment of the language group in question. We categorize the phenomena that affect us in the most significant way, and our vocabulary reflects the priority we assign to the things around us. Sapir goes so far as to suggest, 'The complete vocabulary of a language may indeed be looked upon as a complex inventory of all the ideas, interests and occupations that take up the attention of the commmunity.'[12]

Words name both things and thoughts, and thus vocabulary links and facilitates the twin activities of observation and theory building—activities that are the essentials of the scientific method[13]—and in turn limits them, when the vocabulary itself is limited.

Family physicians, as a group, increasingly espouse the expanded model of 'family medicine' that recognizes the importance of psychological and social factors in the genesis and maintenance of illness. But if the vocabulary of a community is indeed 'a complex inventory of all the ideas, interests and occupations' of the community, then the vocabulary of family medicine — represented by the *International classification of health problems in primary care*[14] that serves as a dictionary for research in family practice—presents a curiously restricted and very biomedical view of the world.

The classification is divided into categories identified as 'diseases of systems', with precise subdivision into pathological entities within the categories. There is a vestigial section of social problems tacked on at the end like an afterthought, and psychological problems find themselves wedged uncomfortably between frank lunacy and abuse of tobacco. There is a wide vocabulary with which to see and detail respiratory infections but only one word for poverty. Infectious diseases are categorized and subdivided with ease while marital and family problems are presented as amorphous chunks.

Hardin[15] referred to the ability to recognize categories and concepts as the 'physiology of language', and suggested that the pathology of language is when it inhibits changes in concepts and interferes with new forms of categorical analysis. A group of thoughts whether gathered into a category, incarcerated in a concept, or captured in a word, sometimes takes on a permanence that inhibits the ability to see a different grouping, or a different way of categorizing. 'Categorical analysis is always difficult. There are no rules for it. It requires insight and courage (or insanity) to slash away the unconscious strictures of language.'[15]

What stops us from 'bursting through'. What limits us from slashing away the unconscious strictures of our biomedical vocabulary? Hardin suggested that it is the abstractions—the symbolic rather than the nominative function of words—that play the most significant part in limiting thought.

If the physical environment, influenced by the social climate, determines the nominative vocabulary then it is the ideological and intellectual environment, again influenced by social factors, that affects categorical analysis and the symbolic vocabulary.

In patient care, biomedicine is the current central abstraction. It provides the focus for medical activity and constitutes the theme for our conceptual understanding of the problems of patients. It determines the way we categorize and analyse. It reflects the prevailing ideology of the medical profession as a whole. It is the language of medical orthodoxy, the mainstream of medical thought and perception.

The family practice environment is both central to medicine and yet also peripheral. It is central in the sense that a major proportion of patient care takes place in family practice, it is nonetheless a 'peripheral' discipline in the sense implied by Marinker.[16] He considered that family physicians live on 'the boundary between the concepts of health and illness; between the physical and psychological component of illness, between the perspectives of psychology and sociology; between the history of the patient and his own future; between the concepts of "cure" and "care".'

The position of greatest comfort and certainty is one which occupies the centre of a system of abstraction and permits what Kuhn called[17] 'normal science'—the rewarding process of continuing subdivision of existing knowledge. The boundary can be acutely uncomfortable as it approaches the categorical limits of current knowledge and, in that sense, approaches insanity.

One problem with working on a boundary is that language becomes vague and uncertain. At the centre of a conceptual abstraction words are simple, precise, easily codeable, readily available, and they are immediately understood by others. At the boundary words become less precise, carry more than one possible meaning, extend into phrases, become more cumbersome.

Diseases that fit easily into the biomedical model are identified with a short name and with confidence. Problems on the boundary are identified with a lot less certainty, and with a collection of words or a complete phrase. The difficulty has been set out by Freer,[18] who pointed out the frustration in problem-orientated family practice records of trying to use one or two 'crisp' words to describe a problem, and recommended a short narrative phrase to describe the problem more honestly. Problems that lie on boundaries, problems that lie on the periphery of an abstraction, defy description and solution until the abstraction is 'burst through' and the focus is shifted so that previously peripheral concerns become central, important, definable and describable. Kuhn has described this process of paradigm change, the uncertainties it engenders, the revolutionary movement it becomes, and the totally new outlook it produces. 'Therefore, at time of revolution, when the normal scientific tradition changes, the scientist's perception of his environment must be re-educated—in some familiar situations he must learn to see a new gestalt. After he has done so the world of his research will seem, here and there, incommensurable with the one he had inhabited before.'[17]

It is a hard change to achieve, and Kuhn in his talk of 'change in tradition' and 'scientific revolution' recognized the reality that, as well as perceptual and conceptual changes, this change in gestalt must break through social barriers. For someone involved in such a revolution, the change affects not only his 'world view' which may or may not be trapped in language, not only his vocabulary which must grow to meet the new demands, but also challenges previously accepted social norms.

Language as a social phenomenon

'The mere fact of a common speech serves as a particularly potent symbol of the social solidarity of those who speak the language.'

Edward Sapir[19]

To suggest that it is only in grammar and vocabulary that language may interfere with thought and perception is to ignore the significant fact that language serves not only communication and thinking, but is also a social phenomenon.

Whatever comes first, whether it is language, culture, perception, or thought, whatever the origin of linguistic distinctions, once made they become part of a mutually supportive cybernetic system,[15] originally channelled by social forces, but which itself becomes a great force of socialization and thus a vicious circle is set up. The sort of society we live in directs the way we talk and see and think in such a fashion that we become closely identified with the society, and our need to remain part of a group we value perpetuates and reinforces the language we use.

Family physicians occupy a place in the community of the medical profession and are under constant social pressure to conform. The medical community is identified by, and identifies its members with, a particular language. Hoijer[20] described language in social terms as 'an historically derived system of explicit and implicit designs for speaking which tend to be shared by . . . members of a group'.

To step outside group norms—to use language which encourages perception and thought peripheral to, or outside the experience of, the mainstream of a group—is to risk at least rebuff or at worst ejection by the group. The dilemma is faced daily by resident family physicians as they move between family practice and hospital rotations. The language appropriate to family practice is often loose, imprecise and has a vocabulary that includes social and psychological terms; when family physicians walk across to a medical floor that same language is subject to derision and censure.

I referred earlier to the 'prevailing medical ideology'. 'Ideology' is itself an interesting word. The concept of ideology reflects a discovery which emerged from political conflict, namely, that ruling groups can in their thinking become so intensively interest-bound to a situation that they are simply no longer able to see certain facts which would undermine their sense of domination. In certain situations the collective unconscious of such groups obscures the real condition of a society both to itself and to others and thereby stabilizes it.

Ravetz[21] wrote of the social forces that such scientific 'ruling groups' exert as they act on as yet ineffective and immature disciplines. He warned of the dangers of interacting and conforming with mature fields in the quest for respectability and acceptance. 'I have argued that it is unrealistic to proceed as if a discipline is mature when in fact it is not, and that it is ill-advised to force it along a path of mechanical imitation of matured disciplines. Whatever model is adopted, the forcing of inquiry into the world of "research" investigating small scale problems totally within the mould of intellectually constructed classes of things and events, is unlikely to bear scientific fruit, either in the present or for the future. By pretending to be what it is not, the immature or ineffective discipline condemns itself to remain in that state, rather than engaging in the sort of work that would open paths to achieving maturity of a character appropriate to itself.'

Perhaps what are ultimately hardest to 'burst through' when trying to re-examine the world are the social and ideological rather than the linguistic or conceptual barriers.

Max Planck spoke with feeling when he noted that 'a new scientific truth does not triumph by convincing its opponents and making them see the light but rather because its opponents eventually die, and a new generation grows up that is familiar with it'.[22]

Conclusion

It is not a new problem—this difficulty of encompassing human values within a linguistic framework that seems more suited to a reductionist, biomedical view, with a vocabulary that is inadequate and in a professional and cultural climate that does not encourage change. It was, according to Crookshank,[23] a problem in the fifth century before Christ, when controversy raged between the Coan and Cnidian schools of medical philosophy, and even at that time the difficulties of language and communication were apparent. The Coans were 'naturists' and took as their concern the organism and disease, the relation of the patient to his environment. The Cnidians, on the other hand, wrote of organs and diseases. For them, as with most conventional diagnosticians, the aim was not the assay of the patient's state, but the identification of his malady with a standardized ideal. The Coans treated each patient individually and symptomatically; the Cnidians treated the disease, specifically and rationally.

Crookshank[23] reviewed the relative success of each school of thought in putting its message across. 'Natural diagnosticians . . . will, perhaps, always suffer by rea-

son of the lesser fitness of their method for verbal communication. They teach by example rather than by the spoken or written word, and their reluctance to employ verbal symbols and handy labels is ill-comprehended . . . but the conventional diagnostician . . . runs the risk of coming to assign real value to his symbols as well as his concepts. If his faith in specific diseases . . . carries him through many a verbal emergency, yet, since this faith has no greater value than the premise of which it depends—the metaphysical reality of species and genera—it may betray him at any moment, blinding him to alternative explanations that open up rich fields of experience and entangling him in the meshes of his own classifications and dogma.' Plus ça change—plus c'est la même chose.

The function of science is to question continually, to challenge continually, not to encourage the perpetuation of conceptual abstractions enshrined as dogma. However, to admit the possibility of alternate explanations for phenomena takes a degree of insanity. 'In complete contrast to theologians, doctors and philosophers only admit to be true such things as they are able to explain; they make their own understanding the measure of all possibilities. These gentlemen understood nothing about my complaint; therefore, I was not ill. For how could one doubt that doctors know everything.'[24]

Family medicine, if it really is an emerging discipline with a scientific mission, faces difficulties in the three major areas I have outlined.

1. The basic structure of the language in the community may be more suited to a reductionist model of medicine which encourages the perpetuation of a world view that sees diseases as 'its'.

2. Our professional vocabulary, and hence our ability to observe and build theories, is limited to mainly biomedical terms, and will remain so until we break through the conceptual abstractions of conventional biomedicine.

3. Such a new vocabulary will distance us from the socially accepted norms of medical language, and hence from the security of membership of an established respected group.

To function as a family physician—to be on the boundary—is to feel alternately the exhilaration of the view that such a position affords, and the frustration that language will not yet stretch to describe the view; to feel the joy of reaching a new level of understanding about patients, and to despair of not being understood by one's colleagues.

What do I see in practice? I tried once to observe and record what I saw by using the conventional family practice diagnostic index.[25] As an exercise in recording and data gathering, it was a moderate success; as an honest reflection of my day-to-day dealings with patients, it was totally inadequate.

What I recorded, but did not 'see', were upper respiratory infections, hypertension, anxiety states, general malaise; what I saw, but could not record, were people, their friends and families, with problems.

I wish I could tell you what I see but at present, I am at a loss for words. So, too—I fear—is family medicine.

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