CONCEPTS IN PRACTICE

Towards a philosophy of family medicine

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THE Royal College of General Practitioners has been asked by several Arab and Third World countries to assist in the development of various aspects of primary medical care. This immediately raises the question: What core content of general practice is exportable? Even more fundamentally: What is our philosophy of family medicine and can it be an acceptable basis for primary care in other cultures?

There are the heated discussions about the advantages and disadvantages of the use of pertussis vaccine. The problems and extent of iatrogenic disease are recognized and have been well documented. A growing lobby of women want to return to natural childbirth and home confinements. In these and many other areas the arguments for and against medical intervention continue. But do we ever go back to the system of ultimate values of our profession? The rights of the unborn child provoke debate on theological as well as medical planes, and even more controversy surrounds the continuation of life for the severely disabled. Do we pursue these debates from a sound philosophical base, or merely from a scientific or historical stance?

While the large-scale debates continue, the individual general practitioner in his daily work consciously or subconsciously steers his patient through conflicting difficulties in accordance with his own value-system: Should he prescribe the Pill to a 15-year-old girl? Should the elderly recluse be left alone in inadequate conditions? Will steroid therapy improve the quality but possibly shorten the life of the patient with terminal malignant disease? If the general practitioner is also a trainer there are other questions: Should he demonstrate an authoritarian or a fraternal form of consultation? Indeed, should he simply provide a learning experience that will encourage self-development in the trainee, or should he also be able to argue the philosophical basis on which that self-development will grow?

Some doctors may protest that they are too busy with their day-to-day work to be concerned with philosophical considerations, but if we do not occasionally consider the underlying logical premise of our professional activities we may find ourselves in unexpected tautological difficulties.

What, then, is the value of philosophy? Bertrand Russell summed it up:

> 'Philosophy is to be studied, not for the sake of any definite answers to its questions, since no definite answers can, as a rule, be known to be true, but rather for the sake of the questions themselves; because these questions enlarge our conception of what is possible, enrich our intellectual imagination, and diminish the dogmatic assurance which closes the mind against speculation.'[1]

The philosophical roots of Western medicine are buried in the mythology surrounding the Greek god Asklepios and his daughter Hygeia. The followers of the God of Medicine believed that the role of the physician was to heal and restore to health, while those who followed the Goddess of Health sought to discover the secrets of maintaining a healthy mind and body. From these mythic origins sprang the twin themes of curative medicine and preventive medicine.

However, such a simplistic approach merely touches the surface of our concepts of family medicine. The ancient philosophers were quick to realize the power of knowledge, and they maintained that scientific knowledge is not true knowledge, because, being visible and subject to change, it is mere opinion and liable to error. Plato maintained in his *Doctrine of forms* that the aim of the true philosopher is to penetrate to the heart of reality, to go beyond the limitations of the physical world to the world of forms. People of many types may be called 'just' because their conduct corresponds to an ideal standard called 'justice'. Men are 'good' only in as much as they measure up to one unchanging standard of 'goodness'. So we discover a second world that is different from the world of visible things—eternal, unchanging, apprehended by intellect alone.

The World Health Organization's definition of 'health', a definition which embraces physical, mental and social well-being, has come under attack partly because people have failed to distinguish between the visible and the invisible. The WHO definition is a proper ideal, but it is, by virtue of its philosophical nature, broad and abstract and, as such, does not lend itself to objective measurement. For working purposes we require a much narrower definition, and one which may vary in time and place, if we are to set objectives

which can be measured and compared. However, the narrower aspect would, in itself, be meaningless with the broader concept of health.

In the pre-Kantian period, Descartes was among the first philosophers to maintain that all sciences are ultimately one science and therefore there is ultimately one universal scientific method. In his *Principles of philosophy* he stated:

> 'Philosophy means the study of wisdom, and by wisdom we understand not only prudence in affairs but also a perfect knowledge of all things which man can know both for the conduct of his life and for the conservation of his health.'

In medicine we have to contend with probabilities, because we have to act rather than wait for certainty. Nevertheless, our actions should not be governed entirely by contingent truths, which are liable to error, but more widely by the underlying philosophy of family medicine.

Much of our knowledge begins with experience, though it does not follow that all knowledge arises out of experience. We must be careful not to confuse facts with knowledge—facts are statements that describe a state of affairs ('Today is Tuesday'), whereas knowledge assembles the facts to make a certain statement. Facts are not true or false, but a statement of knowledge may be true or false depending on how the facts are assembled. A further aspect of knowledge is our belief about freedom in causation, as opposed to believing that everything is controlled by rigid laws of nature. The arguments for freedom were formulated by Kant in his *Critique of pure reason,* and cleared away the limitations of earlier philosophers. This opened up a further avenue in relation to a philosophy of family medicine. As long as one believes in the immutability of the laws of nature, then the course or outcome of any train of events cannot be altered. However, if we accept the possibility of a spontaneity and freedom in causation and a variability in the factors which may influence the state of affairs, then we are drawn into an awareness of moral obligation in our actions.

Conscious of these various threads which have been woven into the fabric of our philosophy, and which are more frequently implicit than explicit, we can turn to what some members of our profession are saying. The Declaration of Alma Ata has clearly stated the concept of primary care that should be provided. But when we look at the content of medical care involved we are immediately faced with questions of cure and prevention, authority and free will, and the underlying ethics and morality. Furthermore, we may ask to what extent this is a philosophy of medical care or a political philosophy.

Social scientists have been saying for some time that disease is a sociopolitical concept masquerading as a biomedical one.[2] By labelling a problem as medical or by naming a disease, people are only indicating that they consider the appropriate method of dealing with it is medical. An example is the problem of diarrhoea in developing countries, which for many years has been regarded as medical but is increasingly being seen, more appropriately, as a political or an economic problem to be resolved by changes in the environment. The scientific medical model has dominated medicine for over a century, but several writers are now questioning this concept. Paterson[3] has written: 'That there are crucial philosophical assumptions involved in the definition of a "disease" has, in fact, been recognized in the mainstream medical press. A more political dimension, however, remains ignored. This is that the role of the nature of society in disease causation and presentation is usually omitted.'

One of the most striking statements was that made by McKeown[4] when he detailed the humanist viewpoint as being:

1. man's right, indeed his obligation to live, and even in certain circumstances to have life thrust upon him;
2. his right to reproduce without regard for the quality or number of his offspring;
3. his right to use and even abuse his own body so long as he does not overtly destroy it or harm others;
4. his right to exploit all other living beings for his own purposes.

At first, some people might find these tenets unacceptable. However, when it is seen that at least the first two of these propositions are based on respect for human life and the belief that virtue exists in promoting man's well-being, parallels can then be drawn between this humanist viewpoint and those of religious philosophy. These are found, for example, in the Biblical command to 'Love thy neighbour', the Koranic 'Slay not the life which Allah hath made sacred', the Buddhist precept of 'The rule of training is to refrain from injury to living things', or the path of strict morality taught by Confucius and Zoroaster and contained in the teaching of the Upanishads. Indeed, respect for human life is the foundation for our own Hippocratic oath; it is a universal tenet, which is reflected in attitudes to reproduction, survival and morality.

As general practice moves forward from being a 'cottage industry' to becoming an established discipline of primary care or family medicine, we need to create a firm foundation. This was commented upon by Schmidt[5] when he wrote:

> 'If family physicians, as a group, do not, in addition to demonstrating clinical confidence, establish a firm foundation of new knowledge, they must accept the unpalatable result that family medicine will become a vocational training scheme rather than a respected part of a learned profession.'

Do we then need to be concerned about the philosophical basis of family medicine? Marinker,[6] when considering the problems facing medical students, asked, 'What are the conceptual tools which a modern medical educa-

THE INFLUENCE OF TRAINERS ON TRAINEES IN GENERAL PRACTICE

Occasional Paper 21

The latest Occasional Paper on vocational training reports on the educational progress of a group of trainees in the North of England. Two groups of trainees were identified, those who underwent the greatest change and those who underwent the least change precourse to postcourse, and their characteristics were compared with the characteristics of their trainers. This is the first time this has been done and several new findings have emerged.

These findings are fully consistent with those of Occasional Paper 18 and add still further support for the present system of selecting training practices. The report will therefore need to be considered by regional general practice subcommittees, course organizers, and regional advisers, and is recommended to all trainers and trainees.

The Influence of Trainers on Trainees in General Practice, Occasional Paper 21, can be obtained, price £3.25 including postage, from the Publications Sales Department, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Payment should be made with order.

PROMOTING PREVENTION

Occasional Paper 22

In 1981 and 1982 the College published five *Reports from General Practice* from five subcommittees of its Working Party on Prevention. These dealt with prevention as a whole, the prevention of arterial disease, the prevention of psychiatric disorders, family planning and child health, all in relation to general practice.

The reports initiated a major debate on the place of prevention in health care. Now another Working Party has produced a discussion document which pulls together the threads of the five reports and identifies practical ways in which their recommendations might be implemented. Implementation, if carried out, would involve many bodies and organizations and have a major impact on health care.

Promoting Prevention, Occasional Paper 22, is available now from the Publications Sales Department, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £3.00. Payment should be made with order.

tion has given them?' He went on to make the point that medical students now need courses concerned with the processes of thinking and the strategies of adaptation rather than the curriculum which is currently on offer. And yet those who propose or examine the philosophical roots of medical practice, such as Illich, McKeown, Draper, Cochrane, to name but a few, often bring down the wrath of the profession on their heads. We prefer just to 'get on with treating the patient' without bothering too much about asking fundamental questions which may underlie our whole approach to the patient.

We are increasingly faced with a combination of technological advances and an awareness that people should take more responsibility for their own health. To whom, as general practitioners, are we accountable—to our patients, our colleagues, or ourselves? And how far is the patient responsible for his own health? The general practitioner is often required to be the guide and arbiter for his patient in the jungle of medical technology and the complexities of ethical issues under the shadow of possible litigation. Can this guidance be accomplished without a philosophical basis? In a rapidly changing world we must not confuse the concepts of principle and practice if we are to adapt to the impact of change on our professional standing as family physicians.

References

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2. Campbell EJM, Scadding JG, Roberts RS. The concept of disease. *Br Med J* 1979; **2:** 757-762.
3. Paterson K. Theoretical perspectives in epidemiology. *Radical Community Med* 1981; **8:** 21-29.
4. McKeown T. Health and humanism. In: *Problems and progress in medical care.* London: Oxford University Press, 1971.
5. Schmidt DD. The family as a unit of medical care. *J Fam Pract* 1978; **7:** 303-313.
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Larynx examination

Examination of the larynx is neglected as a regular part of the physical examination, largely because of difficulties inherent in the angled-mirror technique of visualizing this area. Simple, relatively inexpensive right-angle telescopes especially designed for laryngoscopy are now available to facilitate this examination.

Source: Geyman JP, Kirkwood R. Telescopic laryngoscopy. *J Fam Practice* 1983; **16:** 789-791.