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Published by The Royal College of  
General Practitioners, 14 Princes  
Gate, London SW7 1PU.  
Editorial Office: 8 Queen Street,  
Edinburgh EH2 1JE.  
Printed in Great Britain by  
Thomas Hill Print (1985) Ltd.,  
Bishop Auckland, Co. Durham  
DL14 6JQ.

## Journey to the interior: the search for academic general practice

**T**HE thesis which I wish to advance is full of paradoxes. In requesting a paper on the stable core of general practice, I believe that those who created this conference† were manifesting a profound anxiety about whether or not we really have a subject to teach and research. This academic insecurity is counterpointed and contrasted by a sense of the relevance of general practice to the health care needs of our communities. Furthermore, general practice has had considerable political success in establishing its presence in the university medical schools. Yet we remain nervous about our true identity. We want the reassurance of a solid and stable core to our subject.

There is a great deal of instability in academic general practice, and this is a key characteristic of our subject. In our clinical work we have made a scientific virtue of the ability to tolerate uncertainty. By the same token, if we can learn to tolerate an instability at the core of our academic discipline, we may discover a common ground of general practice, a topography of the interior of general practice which we will be able to describe not in the transient terms of biotechnology, or of the characteristics of a particular society, but in more stable terms of human values.

I am going to suggest that there are five domains of academic general practice. The first is concerned with the *content* of the work, the second with its social and psychological *context*, the third with the *tasks* of the general practitioner, the fourth is concerned with the development of general practice as an academic *discipline* and the fifth with its *values*. Each domain reveals something different about the territory of general practice. Each of these domains is dominated by powerful figures from outside general practice itself. Some of them we recognize and welcome. Others we ignore, and I shall suggest that we ignore them at the peril of our developing discipline.

### Content

The argument for general practice as an academic discipline began with an analysis of the content of the general practitioner's work, and the contrast between this and the experience in hospital. The basis for all of this has been the classification of diseases. Since by its nature, a university subject is universalist, there has grown a thriving industry in international comparison, and this has given rise to enthusiastic exercises in defence of this or that system of classification. WONCA itself has not been untouched by the political passions which such scientific endeavour seems to excite in learned organizations. Let me then sound a cautionary note.

Three years ago we published the results of the following experiment carried out at the MSD Foundation.<sup>1</sup> A series of documentary video recordings of consultations in general practice was shown to groups of experienced general practitioners. In relation to each consultation the doctors were invited to make a diagnosis, and to select morbidity labels from both ICD-9 and ICHPPC-2. They then completed questionnaires which looked at the basis of their diagnoses and choices of manage-

†This paper entitled 'The stable core of general practice' was presented at the Asia Pacific Regional Meeting of the World Organization of National Colleges, Academies and Academic Institutions of General Practitioners/Family Physicians (WONCA) in Hong Kong on 6 September 1987.

ment. A high degree of inter-observer variation was recorded. The doctors chose different diagnoses and a variety of morbidity labels. There was little agreement in what they observed, and what they deduced from their observations. If a group of professional leaders meeting together in London cannot agree about what to call the conditions which they commonly see, what hope for the researcher in London and his colleague in Hong Kong, who wish to compare and contrast their work?

A recent study of general practitioner performance in Manchester<sup>2</sup> demonstrated a wide variance in the behaviour of doctors, with regard to the morbidities recorded, consulting rates, referral for investigation, referral for a second opinion and prescribing. What was interesting about this study was that the search for explanatory variables among the doctors was fruitless. The doctor's behaviour could not be predicted by the size of the practice, its location, the characteristics of the population, the doctor's age, previous medical education or any of the other 'sensible' variables considered. The differences appeared to be individual and idiosyncratic. What was being displayed was what Balint<sup>3</sup> had described as the general practitioner's apostolic function.

In the UK, departments of general practice often began life within divisions of community health. It is scarcely surprising therefore that the domain of content is populated by epidemiologists and demographers. More disconcerting, however, is the discovery that much of their basic data are in the hands of illusionists, conjurers and magicians.

### Context

The problem with morbidity classifications is not that we do not yet share a common language, but that we may not share the common experiences and orientations which are manifested by a common language. It is evidently possible to invent an international classification, in much the way in which Esperanto was invented. But the invention of such morbidity esperantos, although it may help us to communicate, will not deal with the substance of that communication. One may write poetry in Esperanto. But because Esperanto has no strong roots in its own culture, its poetry cannot convey the same sharp sense of time, place and belief which we get when we read the poetry of Herbert, Coleridge and Auden. The English in which they wrote was not simply the vehicle of their thoughts, it shaped the thoughts themselves. The language was the culture. The medium was inextricable from the message. Their poetry could not have been written, could not have been thought, in French or German or Japanese. In our journey to the interior of general practice, we have entered the domain of context.

If you were to transfer a renal surgery unit from London to Hong Kong, the team would be able to function in its new location with equal technical mastery. The same would not be true of a general practice. More than any other compartment of medical care (perhaps with the exception of psychiatry) general practice reflects and is materially defined by the culture within which it practises. The presentation of a patient with dyspepsia is mediated by the health beliefs that he has inherited, by the local traditions of healing, by the power and ambition of medical institutions, by the social welfare system and much else besides. The willingness to assume that the dyspepsia is an early warning of serious gut pathology, or an expected manifestation of endemic alcoholism, or a minor vicissitude which will yield to the prescription of a chalk mixture, or the final declaration of an unconsumed marriage, is a matter at least as much of culture as of medical science.

We should not expect to practise within contexts which are recognizable, or even understandable to one another. Yet what general practice may have in common across the frontiers of national experience is the close attention which we pay to that context. In this domain our preoccupation with academic respec-

tability should not blind us to look only for the sociologist and the anthropologist, however comforting their company. Those who exercise real influence in the domain of context are the advertising executive, the maker of soap operas, the fashion designer and the singer of popular songs.

### Tasks

The third domain concerns the definition of tasks. Here for the first time the voyager will discover some order, some stability, a sense of security. Most national organizations concerned with general practice, and certainly most medical schools, have produced job definitions. Many bear a resemblance to the job definition of general practice first drafted in the University of Manchester, and first published some 15 years ago in *The future general practitioner*.<sup>4</sup> International groups have produced similar statements.

These statements serve a number of quite varied purposes. They serve an academic purpose, permitting us to spell out the goals of our teaching and the standards for assessment. They serve a psychological need: the manifestos boost the morale of general practice, and particularly of academic general practitioners. Above all, they serve a political purpose. In this sense the educational objectives which we write may be less the fruits of empirical research than the imperatives of political ambition. I write as someone who was personally involved in the drafting of these early manifestos. Statements like 'The general practitioner will compose all of his diagnoses simultaneously in physical, psychological and social terms', still convey the *frisson* of singing the Marseillaise. Singing the Marseillaise may make us feel very good about liberty, equality and fraternity, but the lyric hardly spells out a precise methodology for bringing them about. Pledging ourselves to make a triaxial diagnosis scarcely explains how we will integrate the dyspeptic patient's unemployment, what this does to his self-image, the punishment which his wife inflicts on him, the time and the opportunity to drink beer, and the changes in his gastric mucosa.

Perhaps the domain of task, like those of content and context, is not quite so well ordered and stable as we might have wished. Our educational objectives seem, on close inspection, to have as much to do with making the doctor feel good, as with making the patient feel better. Did we really expect to find the domain of task populated only by teachers and researchers? Is it so much a surprise to recognize the public relations consultant and the political agent as fellow travellers on this journey to the interior of general practice?

### Discipline

It is when we enter the domain of the discipline of general practice that we leave behind the last illusions of stability which were offered by the enumeration of content, the recognition of context and the publication of tasks.

A discipline is a field of study with preferred methods of enquiry. Immediately, this poses problems for academic general practice. The astrophysicist will be concerned with the red shift, but scarcely with the constancy of the internal environment. The nephrologist is preoccupied with pressures across membranes, but scarcely with the meaning of dreams. The general practitioner, whose job description tells us that he makes an initial response to all the problems which his patients bring, and that his diagnoses will be composed simultaneously in physical, psychological and social terms, is hard pushed to draw the line. Is he concerned with applied physiology and pharmacology? Certainly. With communication and human development? Yes. With family dynamics and microeconomics? Well, yes. With moral philosophy and the psychology of the built environment? Probably. With aesthetics and industrial relations? Sooner or later, on the boundaries of our experience and our inclinations, the chorus of territorial claims begins to falter. So much for the

boundaries of our field of study. What of our preferred methods of enquiry?

In modern times medical research has been driven by three powerful ideas which have their origin in the intellectual flux of the seventeenth century. First, the iatromathematicians based their understanding of disease on machines, on levers, mills, waterworks and the like. Second, the iatrochemists based their understanding of disease on the chemistry of gases, on combustions, distillations and fermentations. These two approaches continue today to be the bases of most biomedical research. The third approach, classification, arose when Sydenham brushed aside these early theories, on the grounds that they had proved to be largely unsuccessful. He replaced them with direct observation and invented the pathology of patterns: he was able to distinguish between scarlet fever and measles, between chickenpox and smallpox, between gout and other afflictions of the joints. It is this nosography which constitutes the ground on which modern clinical epidemiology is based.

Perhaps what we can most profitably learn from this synoptic history is the changing and ephemeral power of one model or another to explain. Sydenham was right to be contemptuous of the iatromathematicians and the iatrochemists, although their approach was to triumph two centuries later. Yet a century after Sydenham's scientific revolution, his approach in the hands of de Sauvages resulted only in a sterile classification of conditions which added nothing to our understanding.

My point is that the acquisition of knowledge and the building of theory have not simply been the product of logic, observation and experiment. They have been influenced by fashion, by the changing needs of society and occasionally by the imagination of remarkable and turbulent individuals. My fear for academic general practice is that it may develop along lines laid down by fashionable research which is neither consonant with the clinical experience of general practitioners nor central to their concerns. Most published work is now numerate rather than narrative. The validity of its findings is limited by what measurement alone reveals. The variables which are measured have for the most part been unquestioningly imported from other traditions of medical research, where they have already proved to be powerful and successful. But close to the interior of general practice, these methods have resulted in banal questions and largely predictable answers.

In the 1960s the Balint tradition of research promised much. I want to consider three aspects of this work. First, it was based on elegant theory. Psychoanalytic theory is unbridled in its claims to explain the entire human condition. Medawar<sup>5</sup> comments tartly on the Olympian ambition of a theory which seeks to embrace at once the causes of constipation and anti-semitism. The success of psychoanalysis has been varied, but perhaps more remarkable in the fields of art, history and philosophy than in medicine. In clinical psychiatry the results have been relatively disappointing, and the fashion is already fading. Similar criticism was levelled by Sydenham at the iatrochemists and the iatrophysicists. Two centuries later iatrochemistry and iatrophysics dominated a burgeoning and successful physiology.

Second, although the ghost of Freud haunts the early pages of the Balint literature, the work described is unmistakably the rude experience of practising doctors. Narratives reveal the twists and turns in the plot of the doctor-patient relationship, where fiction has no place. The contrast with the theories of social scientists could not be more sharp. Stories are full of the unexpected. Surprise is with us at every turn. Where there should be climax there is bathos. Where there should be diagnostic defeat we find a therapeutic gain. The elements of surprise, of unpredictability, and above all of untidiness and incompleteness suggest that we are in the presence of real scientific discovery.

Third, the Balint approach was capable of running our medical thinking off the rails of our medical education. A study of patients receiving repeat prescriptions<sup>6</sup> revealed that this group of persons appeared to need continuing support and con-

tact from their doctors, but could not bear too much intimacy. The research was painful, and the researchers ashamed of the very clinical work which they were exploring. Prescriptions had been issued, often over a period of many years, and almost always in the absence of any meaningful clinical work. Yet the patients remained well, and only became ill again when the doctor attempted to be rational, to do good clinical work, to reopen the question of diagnosis and sensible treatment. Slowly it dawned upon us that the treatment itself was the diagnosis. We were forced to redefine the most basic terms of clinical thinking.

I have only used the Balint tradition as an example: I am not making a special plea for this approach. Nor do I wish to suggest that the current fashions in which general practice research is being carried out necessarily produces inappropriate work. Thomas Kuhn<sup>7</sup> tells us that when new paradigms of science are discovered, they do not oust the old but incorporate them. What I am suggesting is that the relative poverty of general practice research may suggest that we are asking the wrong questions, or that the tools of exploration are inappropriate for the tasks, or that academics in general practice have become the political prisoners of an alien regime — the modern medical school.

In the domain of the discipline, we recognize the epidemiologist, the statistician, the pathologist and the social psychologist. These respectable citizens have given the domain of discipline the appearance of a prosperous commuter village, with fast trains to the medical school. I have suggested that the domain of academic discipline in general practice may be a far more bohemian neighbourhood, and that our experience of it may be enriched by the company of the art historian, the cryptographer and the growing number of researchers who are exploring the validity and reliability of the narrative as a basis for human research. Most surprising of all, the work of these new researchers which seems so far removed from the contemporary medical tradition, bears a remarkable resemblance to that of Sydenham, Graves, Addison and others whose classical descriptions of disease still frame our clinical thinking.

### Values

The development of general practice as an academic discipline will depend on the values which we bring to our endeavours. These values must not only inform the field of study to which we lay claim, but also the methods of enquiry which we employ. They must also be true to general practice itself. At the centre of general practice is the encounter between the doctor and the patient. If we fail to value the uniqueness of the doctor and the patient, the role of feelings and situations in the interpretation of symptoms and findings, we are condemned to be second rate players in a second hand game.

If medicine were simply a field of scientific endeavour, the development of so many different areas of study and methodologies would already have resulted in the break-up of medicine, and the invention of a number of daughter disciplines. It is hard to see what psychiatry and orthopaedic surgery and neonatology would have in common.

Two elements continue to suggest the unity of medicine. First, the survival of the idea of a common medical school education for all doctors. Second, the persistence of general practice in most societies. If there is something stable and universal in general practice, it may be found in our shared values — values shared by doctors not only across national frontiers, but across the frontiers of specialization. The role of academic general practice may therefore become that of the keeper of medicine itself.

We are entering an age of unprecedented acceleration in biotechnological and societal change. General practice, because of its peculiar tradition of living with uncertainty may thus be uniquely equipped to ensure the survival of medicine as a coherent whole in the next century.

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## The teaching of medical ethics

THE Pond Report,<sup>1</sup> a recently published report of a working party on the teaching of medical ethics, was commissioned by the Institute of Medical Ethics and prepared by a formidable committee of clinicians, philosophers, nursing teachers, a professor of law and a professor of theology. Their brief was to address the question to what extent, and in what manner, should the teaching of medical ethics become part of the curriculum for medical undergraduates.

The report distinguishes two meanings of 'medical ethics'. The first concerns standards of professional competence and conduct, and embraces formal codes of practice which doctors are advised to follow. The second refers to the study of ethical or moral problems raised by the practice of medicine. These problems may take the form of 'ethical dilemmas' but are just as likely to arise from everyday actions of doctors.

It is appropriate that the recommendations of the report address the second meaning of medical ethics, thus eschewing the idea of ethics as 'rule-following'. The essence of morality lies in individuals evaluating and assessing moral issues for themselves. The idea that it is possible to arrive at a perfect code of practice is a myth that has been repeatedly exposed as such by generations of moral philosophers. Ethics is not a science but a personal activity. Sheep and monkeys can follow rules, but moral reasoning is a higher art. Sometimes it happens that the same conclusion is reached whether rules are followed blindly or a painful personal analysis is undertaken. But, as Jonathan Glover writes in an appendix to the report,

'... I would prefer the decision about whether or not to keep me alive to be taken by someone who had thought systematically and clearly about the kinds of reasons that could be given, rather than by someone who went by what the consultant told him when he was a student. They might come to the same decision, but the difference in the quality of thinking behind it is not trivial.'

The report's 12 recommendations urge that the art of moral reasoning, an essential medical skill, should be encouraged in all medical undergraduates. The following recommendations are among the most significant.

- 'Medical ethics teaching should recur at regular intervals throughout medical training, and time should be set aside within existing teaching for ethical reflection relevant to each stage of the student's experience.'
- 'Clinical teaching of ethics should normally begin from clinical examples. Such teaching should be exploratory and analytic rather than hortatory...'
- 'Interested medical teachers should be encouraged and assisted to undertake further study of medical ethics in the context of courses already available.'
- 'Care should be taken to avoid leaving ethics teaching in the hands of a teacher whose tendency is to promote a single political, religious or philosophical viewpoint.'

The Institute of Medical Ethics is to undertake a reassessment of teaching options and the working party's present recommendations in five year's time.

These recommendations have placed the teaching of ethics, for so long regarded as a peripheral activity, firmly on the agenda for medical education. Within the next five years the necessary facilities and teachers to educate medical students in this ancient discipline will have to be found. Philosophers may become involved and clinical teachers with experience of teaching ethics will find themselves with additional responsibilities. It is also likely that general practitioners, particularly those in teaching practices, will have an increased opportunity to teach medical ethics.

This is indeed a challenge. If ethics were a question of learning formulae and adhering strictly to authoritarian codes of practice, then teachers of general practice could simply train students in the technique. But this is not the nature of ethics. Many ethical dilemmas have at least two solutions, each of which can be justified by reason. How are general practitioners to begin to cater for such complexity and uncertainty?

Although ethics permits a variety of opinion it is not the case that any solution to an ethical dilemma will be as good as any other. There are five key features on which teachers of general practice should concentrate.

1. *Clarification*. It is essential that students become proficient in separating the key elements of a case in order to have an uncluttered picture of the problem.

2. *Alternative perspectives*. There is a classic distinction in moral philosophy between those who advocate obedience to principles or duties, and those who believe that ethical deliberation should focus on the calculation of the most beneficial consequences. As students become aware of these alternatives the complexity of apparently simple problems becomes obvious. But this distinction can help to provide solutions. Most moral philosophers argue that ideal moral reasoning lies somewhere between these two extremes.

3. *Analysis*. Students must be able to weigh up the key considerations, balancing one against another.

4. *Justification*. Students must become adept at justifying their analysis, and the conclusions derived from this analysis. Once doctors realize that the onus of moral choice rests on their shoulders rather than on vague codes of practice it becomes vital that they can answer certain questions to their own satisfaction: why did I do this and not something else? can I be sure that I genuinely did the best I could as I understood the situation?

5. *Integrity*. None of the four key features listed above carry any weight unless the teacher can convince the student that personal integrity, intellectual stamina and honesty are essential to the process of moral reasoning.

The pressure is on individual doctors to arrive at the most