Anecdotes and empiricism

IN the modern, progressive world of general practice there seems to be a trend towards scientific justification. The standard of empiricism is being raised high and cries are heard that much that general practitioners do has not been properly evaluated by scientific trial.[1] At a time when clinical audit is beginning to dictate practice it is important to stress that much of what general practitioners do is inherently not amenable to testing by trial but is based on knowledge obtained in a different, but no less valid, way.

The evidence on which a general practitioner works might be described as anecdotal rather than empirical in the sense that seeing patients in the context of their own lives (and life stories) is of the utmost importance in diagnosis and explanation and in planning treatment. The description 'anecdotal' will immediately damn this approach in the minds of those who hold up the randomized controlled trial as the gold standard in medicine.[2] But should it? There is a need to balance these disparate approaches and to this end it is important to examine more closely the use of anecdotes in medicine, both in learning and in practice.

Anecdotes are generally regarded as short, pleasant and humorous stories told in sociable situations. They are seen as light and trivial, carrying little weight in serious discussion. The context in which the term is used by doctors bears this out: 'there is only anecdotal evidence for that' is a put-down frequently heard at medical meetings. However, at the same meetings, anecdotes (although not recognized as such) may take on a different significance. A speaker presenting a scientific paper will tend to illustrate the talk with a story about a patient he or she has treated. It is often only at this point that the audience sits up and takes notice. The essential features of an anecdote here are: first, that it is being told about a patient personally known to the speaker; secondly, that it is being told by a doctor personally known to the audience (as the speaker is, at the very least, standing there in front of them); and thirdly, that it refers to a unique individual in a unique situation rather than to a group experience (as in a randomized controlled trial). Because of these features the anecdote may have a greater impact on the audience than the scientific paper in that it is both memorable and believable; its effect on their practice may even outweigh the effect of the paper. General practitioners tend not to change their practice simply on the basis of results of trials; they are more impressed with wisdom passed on through someone's clinical experience.[3]

The 'I remember a patient once' scenario is also an important aspect of medical education. Clinical medical teaching is done on an apprentice basis where the experience of the teacher is handed down largely by anecdotes: the case of one patient will be contrasted with that of another patient whose presentation was similar but memorably different. Undergraduate students are therefore confronted with the uniqueness of each individual's illness. From seeing people as homogeneous (in the scientific preclinical years of the course) students learn the reality of medical practice through the experiences relayed in narrative by teachers and patients alike. In fact, they already knew that people were all different, it was just that medical education was trying to teach them otherwise:

> 'The first staggering fact about medical education is that after two and a half years of being taught on the assumption that everyone is the same, the student has to find out for himself that everyone is different, which is really what his experience has taught him since infancy.'[4]

Learning clinical medicine traditionally starts with taking case histories. Students learn to allow patients to unfold the story of their illnesses in their own way without interruption before homing in on specific symptoms for clarification. Students are often asked to record the presenting complaint in the patient's own words without first putting a clinical gloss on it. 'I'm that breathless I can't even climb the stairs with the shopping' says much more about the meaning of the illness to that individual patient than 'exertional dyspnoea NYHA [New York Heart Association] grade 2'.

The way in which a patient orders events in his or her story can be highly meaningful. Compare two presentations of breast cancer:

> 'About a month ago I fell against the banisters and it was just after that that I felt the lump.'

> 'I don't usually examine myself but about a month ago I fell and hurt my chest and when I was rubbing on a pain reliever I felt the lump.'

The first patient clearly feels that there is some connection between her injury and the development of cancer whereas the other patient views her injury as fortuitous as it allowed her the opportunity of discovering the lump earlier. If the doctor ignores these narrative distinctions then the patient can be left confused and disoriented, with many questions left unanswered. Alertness to the patient's story allows the doctor access to a deeper understanding of the patient, beyond the purely scientific and pathological.[5]

Allowing a patient to tell his or her story completely can be an important part of the therapeutic process. This gives the patient the opportunity to order and clarify in his or her own mind the experience of the illness and helps the patient towards understanding it. It is surprising how difficult it is to listen properly to a patient's story to its conclusion. But it is important to do so because if the doctor interrupts with comments these are often completely ignored by the patient who wishes to finish the story. As Peter Hoeg's heroine comments in his book *Miss Smilla's feeling for snow*:

> 'Very few people know how to listen. Their haste pulls them out of the conversation, or they try internally to improve the situation, or they're preparing what their next speech will be when you shut up and it's their turn to take the stage.'[6]

Patients' medical knowledge and attitudes towards disease are often built up from a series of anecdotes about what has happened to family or friends. Most doctors will be familiar, when trying to persuade a patient to give up smoking, with the story of uncle Jimmy who smoked 30 cigarettes each day and was still playing bowls at the age of 80 years. It should be remembered that such anecdotes are usually true and that the patient has a point. Uncle Jimmy is proof to the patient that the doctor's warnings could be wrong and that the much publicized scientific evidence of the risks of smoking is not absolute for the patient as an individual. So the doctor's approach to the patient's illness (or to the patient's potential to be ill) should be tempered by the inherent uncertainty of much medical knowledge and by the unpredictability of a disease process in a unique person.

Each episode of illness in a patient is described by doctors in letters or medical notes which build into a history of the person's medical life. No general practitioner summarizing case notes or hospital specialist reviewing notes can fail to be struck by their biographical aspect. This is particularly so as the entries often go beyond a factual account of illness and comment on personality and personal relationships. For example, patients have been described in medical notes as 'tall, thin, anxiety prone, introspective' and 'wily'. It is not just by chance that these comments exist because the context in which patients live is of great importance to the ways in which they react to illness. The significance of these comments as biography should not, however, be overstressed. The patient makes no direct contribution to the descriptions and the entries are a doctor's view of the patient in a situation of stress; from the patient's point of view, illness events may be of little significance in the totality of his or her life.

Anecdotes and stories, therefore, are integral to medical practice[7] and to the education of those practising it. Learning the scientific basis for understanding people is only one part of the holistic approach to which students must aspire. Downie has pointed to other types of understanding, including the narrative, historical and sympathetic modes.[5] Anecdotes and stories involve narrative and historical understanding but also contribute greatly to sympathetic understanding. However, anecdotes and stories can only achieve this if the doctor appreciates their importance and takes time to listen.

Although knowledge obtained through scientific endeavour in medicine is being vaunted as superior to knowledge obtained in other ways, learning from anecdotes and stories and being alert to their use by patients are essential to good medicine. This kind of knowledge enables doctors to deal with patients as individuals and to respect their uniqueness as persons. As George Eliot in her novel *Middlemarch* said of Dr Lydgate:

> 'He cared not only for 'cases', but for John and Elizabeth, especially Elizabeth.'[8]

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There is hope yet for the development of primary health care in deprived areas

THERE is no point in arriving too early for morning surgery because the patients will not be there: it seems that an appointment with the doctor is not enough reason to get people out of bed in this inner city practice in Liverpool.

A similar observation was made on the *Panorama* (BBC) television programme 'rich and poor' on 13 February 1995 about the behaviour of people in Drumchapel, a deprived area of Glasgow, compared with affluent Bearsden. The programme repeated what is known by anyone who has worked in a deprived area — a key problem is the lack of hope. The reality of living in a deprived area is that one is confronted on a daily basis with personal failure, violence, unemployment, fragmented communities and lost dreams. The result is that individuals, families and communities come to lack purpose and self-belief. Working as a general practitioner I see men and women in their early 20s who are resigned to a life on 'the dole' or on 'the sick', people who have no idea what they want out of life, what they believe in or with whom they identify — people who have difficulty getting out of bed in the morning.

They are not alone. The report of the Royal College of General Practitioners inner city task force[1] reminds us that primary care teams often exhibit the same features as their patients — of being overwhelmed, unable to find optimism or direction. For individuals, communities and health workers alike, two of the most pressing priorities to address are the need to locate themselves in a wider picture and to feel good about who they are.

The problem of inequity is itself of considerable importance. The Black report of 1980[2] demonstrated the profound association of deprivation and poverty with sickness and the situation has worsened since then: over the last 15 years the rich have got richer and the poor poorer and mortality and morbidity gaps have followed the same pattern.[3,4] This has resulted in the preparation of a range of books that suggest practical ways forward.[5-7]

The catch is that deprivation and poverty are not the only causes of hopelessness. The anonymity, struggle to survive and fragmented communities characteristic of deprived areas promote a loss of direction and with it a loss of hope. Jobs and housing alone will not be enough to give people a sense of identity or create a vibrant, positive culture, nor will more staff ensure that general practices in deprived areas become happier places. Interventions are needed, both in local communities and in general practices, that help people to become confident. This is the field of development.

To develop means to grow or to evolve. The word development is used in many different contexts, for example personal, service and organizational development, community development and sustainable development. All share (or should share) a common aim of moving forward.

A development approach focuses on people rather than topics. It accepts individuals and groups for what they are and helps them to change in a way that personally empowers them and also helps them to interact better with the world around them. Such a