Mackenzie's puzzle — the cornerstone of teaching and research in general practice

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SUMMARY

The new-found popularity of generalism as a political force has emphasized the need to clarify the essential philosophy that underpins its practice, teaching, and research. Drawing on the example of Sir James Mackenzie, the author seeks to clarify certain essential issues that need to be emphasized if we are to promote and develop general practice as a distinct academic discipline. Dissatisfaction, uncertainty about our role, and continuing contact with real people seems to be essential to continuing creativity.

Keywords: academic general practice; research; theory.

Mackenzie's puzzle — the hub of academic generalism

A common experience of generalists is that their medical education has not prepared them for an adequate understanding of what they see or hear when they consult with patients. Sir James Mackenzie[1] put it this way:

> I was not long engaged in my new sphere when I realized that I was unable to recognize the ailments in the great majority of my patients... For some years I went blundering on, gradually falling into a routine, i.e. giving some drug that seemed to act favourably on the patient, till I became dissatisfied with my work and resolved to try and improve my knowledge by more careful observation.

This puzzled feeling has been replicated in many others and is now being experienced even by undergraduates as they are introduced earlier to the realities of how symptoms originate at the level of the person, the family, and the community. In our medical schools, the mismatch between what the books say and what the patients feel can go unrecognized by teachers, and, as a result, like many cultural and racial groups, family physicians, residents, and students can find themselves in a state of blundering similar to that experienced by Mackenzie. While there is widespread awareness of the 'blunderings' of family doctors, there seems to be no understanding that the blame should not be placed only on the doctors' ignorance or on their education. Often the real culprit is the mismatch between what doctors know and what patients wish them to do for them: what Schumacher[2] might describe as 'an inadequate and impoverished view of reality'. Mackenzie's solution to his blundering was a determination to try to understand his world by careful observation, which led to the evolution of cardiology as a specialty. However, while confident cardiologists prosper, generalists still seem to blunder.

Resolution through dissatisfaction

All over the world, generalism has become a desirable commodity for those who wish to correct the ills of medical practice and medical education. In the United States (US), there is now a commitment by the American Association of Medical Colleges[3] to set the goal of training the majority of the graduates of medical schools as generalist physicians. This is an encouraging sign, but we have to remember that the enthusiastic welcome would not have come had it not been for a crisis, which is directly related to the blundering that Mackenzie experienced. Doctors still seem to 'gradually fall into routines' and 'give some drug', and only seem able to understand the health needs of individuals, families, and communities after they have spent a great deal of money on procedures and treatments.

How is the academic wing of general practice, in the shape of colleges and departments, responding to this crisis? Certainly not by public admission of dissatisfaction, although determination to improve our knowledge by careful observation has been a growing tendency. We have risen to a position of potential importance in the corridors of health ministries and medical schools, yet, heady with power, we still seem to be unable to offer anything distinctive or useful to help with the crisis. There are also signs that our bedfellows seem not to understand what we have to offer: Weiss[4] has commented on the situation in the US, where academic family physicians are being sought as service providers and income generators rather than 'investigators, concept developers, and analytical thinkers.' In other countries, we are being sought to provide geographical diversity, as if seeing patients in 'the community' made any difference to the blunderings.

Attempts at improvement

In defining our distinctive contribution, we need to realize that the crisis results from what Senge[5] has called a 'tragedy of the commons', where 'individual decision makers, free to dictate their own actions, achieve short-term gains from exploiting the resource but do not pay the cost of that exploitation, except in the long term.' Just as unopposed β-agonist therapy may produce bronchial hyper-reactivity, so unopposed specialist medicine has left us with a vulnerable wasteland of health provision where professionals and patients are now paying the cost. The only solution to this crisis lies in the development of a balanced corporate vision, which will sustain the profession of medicine,[6] and the contribution of generalism to this vision will arise from careful observation of what is going on before our very eyes as we meet our patients. There are three main areas of concern that we will examine in turn.

Promoting and sustaining the live generalist?

It seems that, in most cultures, the majority of people would prefer to have 'their own doctor'. Satisfaction studies[7] indicate that, even in teenagers,[8] general practitioners carry out their task to a high degree of satisfaction from the consumer. While evidence can probably never be conducted to prove it conclusively, patient outcomes seem more beneficial where a quality GP consultation prefaces specialist investigation.

How do we ensure quality in the maximum number of these consultations? If a consultation by an experienced family physician is to be regarded as at least the equivalent of expensive investigation and treatment, then the standards for our artistry and clinical competence will be extremely demanding. However, it should always be remembered that even Pavarotti would be affected by continual interruptions. Morale in the profession is

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Submitted: 27 September 1996; accepted: 2 April 1997.

very important and has to be fostered.

The consultation is a live performance, the objective of which is the achievement of the best possible result, given the doctor, the patient, the family, and the predicament. We know that where we sit is the source from which many rare, potentially fatal, and remediable problems arise, but these occasions are comparatively uncommon. At other times we have to reassure the patient that all is well, and this may be as difficult as providing positive proof.[9]

A recent College Working Party report[10] correctly emphasized the types of personal skills required by generalists if they are to achieve consistency in clinical competence, and advocated a mixture of 'high use' and 'high risk' skills; but how do we select for these skills in entrants to the discipline? When consultations fall apart, must we necessarily assume that the doctor has 'failed' and that some rehabilitation must be arranged? It is beyond question that there are doctors whose consulting behaviour is destructive, but even the best doctors can be destructive from time to time, and this is usually due to a combination of factors. The only solution is to ensure that all new entrants possess the dissatisfaction that Mackenzie described, and to devise ways of ensuring that this inbuilt mechanism has a long shelf life.

Where, in our undergraduate education, do we promote the live theatre of the consultation and the autonomy of the patient in the consultation? The foundations for competent consulting have to be laid down in the early undergraduate years, and the clinical models used have to include the 'not sick', 'not yet sick', and the 'inexplicably sick', as well as the 'definitely sick' seen in the hospital and the specialist clinic. How these models of consultation are to be delivered, when most clinical teaching is done in hospitals and when only 6% of academic posts are in general practice,[11] is a matter for concern but not despair. The omens are not good for us for a very good reason: as the deliverers of oral forms of communication, we are fighting against the dominant technology of our culture, and the live performer has been marginalized by visual technologies that foster fragmentation, specialism, and bureaucratic solutions such as managed care and health maintenance organizations.[12] Fortunately, the battle is for the hearts of students dependent on portrayed artistry, and victory is assured provided that we bravely assert the necessity that those who will spend their careers as live performers should have written, learned, and assessed objectives in this domain; no-one else plays this role quite like the generalist; therefore, academic departments need to develop this task.

Research as a burning question

If it is true that where we consult is a rainforest with unique and exotic flora, then it has to be explored by those who have love and respect for its ecology and a desire for its preservation. The main lessons that Mackenzie teaches us are that research questions for family medicine arise as puzzles as we consult with individuals, families, and communities who are neither randomized, controlled, nor age- or sex-matched, and where the population under observation, most commonly numbering one, provides no power to generalize and is subject to bias and confounding.

Paradoxically, we prepare our embryo academics for none of these difficulties, and most of them crave expertise in 'respectable' research. This creates a dilemma in the form of a question: do we pursue research as part of an initiation rite for academia, or as a necessity for the answering of questions? Like naive natives forming cargo cults, we seem to be suckers for imported research innovations, answers in search of questions. We had Balint and educational theory, and now we have evidence-based medicine, the extremist missionaries of which seem to preach that unless you can prove the effectiveness of a treatment or procedure by means of a properly conducted randomized controlled trial, you should not be doing anything. Fortunately, the founders of this new discipline have put the record straight by distinguishing between 'evidence-based' and 'evidence tyrannized' medicine, and have emphasized the importance of clinical judgment in the consultation,[13] but why do we not see more evidence of research that is sensitive to the culture of the consultation, in which humanity has more place than mathematics?[14]

There are many other ways to answer such questions. Schon[15] has advocated 'reflection-in-action', which is ideally suited to the artistry of the consultation, and others have applied this technique to the consultation in family medicine.[16] Qualitative methods are ideally suited to a more ecological method of research into the particulars of individual encounters,[17] and there are fascinating semantic issues to explore, such as 'naming'[18] and other strategies in clinical reasoning.[19] Again, there is a Mackenzian need for bravery in pursuing the unanswered question wherever they might lead and whatever the cost in respectability. It would seem that we are producing a generation of research methodologists who can produce correct answers to questions that none of us would ever need to ask.

Respectability or counterculture?[20]

Although general practice is experiencing a new-found sense of political importance, generalism seems to be suffering from low morale. Many reasons have been advanced for this, but perhaps the key problem lies in the inability of generalism to maximize incomes and occupy a position of perceived importance in the public eye. At times, we have an obsession with 'the good old days', when family doctors ruled the roost; and our complaints of fragmentation, loss of control, and professional competition betray a lingering preoccupation with paternalism. James Mackenzie[21] had lunch at 1 pm every weekday, followed by a nap, and on two afternoons a week he played golf. Should we still pursue this utopian dream?

In recent British history, we have demonized both the socialists who spawned the National Health Service and the monetarists who devised the 1990 contract. Is this swing diagnostic of an inability to adjust to political reality, and does it betray the same linear view of the world that impedes our clinical work and our research? Like it or not, this is not a cosy, paternalistic world full of certainties like diagnoses, families, evidence-based guidelines, compliance, success, academic achievement, and secure pensions. Most of the time it is a world full of failure, unemployment, addiction, loneliness, rejection, uncertainty, and poverty — who are we to presume that from time to time we should not share these wounds and sorrows? We live in a postmodern world where, for most, the dreams of success have disappeared. Is it not time to seek a more neutral political agenda, what Young[22] has called 'the politics of difference', which recognizes that our profession will need many variations on the theme to meet the needs of some very different kinds of people? This might mean jettisoning some dearly held beliefs such as face-to-face care, continuity of care, a full-time work ethic, and even independent contractor status.

Politics is the art of the possible, but the power games associated with medical politics can make responding to patients' needs impossible.

Conclusion

Recently, Howie[23] has expressed concern about the low credibility of general practice research, in spite of its expansion over the past 30 years. He draws a parallel between the well-meaning research community and the driver who has taken a wrong exit

and worries about getting back on course. Sir James Mackenzie turned off course to become a specialist in Harley Street, and 20 years on, after a knighthood and an FRS, it was probably the same worry that turned him back to St Andrews and the Institute of Clinical Research. That was hardly a credible success in spite of the considerable emphasis given to values and concepts. What it lacked was the living questions encountered every day in Burnley.

The generalist and the academic are irritable companions because the academic is always supposed to know where to go next, while the generalist never knows exactly where he or she is going. Therefore, survival for the academic generalist depends on an inbuilt awareness of where we are, as opposed to where we should be, and a tolerant attitude to dissatisfaction — indeed, a love of it. Credibility will depend on the survival of clinical general practice, which is absolutely dependent on the creativity of our academic discipline.

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