

wrist fractures among HRT users.<sup>15</sup> These findings are supported by randomized controlled trials which show that HRT protects against postmenopausal bone loss while treatment continues. Maintenance of bone mass for even a few extra years during the perimenopausal period is probably enough to materially affect the lifetime risk of fracture, although the exact length of treatment required remains unclear.

There can be little doubt that HRT is useful for the relief of menopausal symptoms relating to oestrogen deficiency. More information, however, is needed about the overall balance of risks and benefits associated with each HRT preparation used for varying durations by women at differing levels of disease risk. Only when such data are available can the primary health care team help women make fully informed decisions about whether to use HRT to prevent disease.

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## References

- Moorhead T, Hannaford P, Warskyj M. Prevalence and characteristics associated with use of hormone replacement therapy in Britain. *Br J Obstet Gynaecol* 1997; **104**: 290-297.
- McCormick A, Fleming D, Charlton J. *Morbidity statistics from general practice. Fourth National Study 1991-1992*. [OPCS series MB5, No 3.] London: HMSO, 1995.
- Vessey MP, Villard-Mackintosh L, McPherson K, et al. The epidemiology of hysterectomy: findings in a large cohort study. *Br J Obstet Gynaecol* 1992; **99**: 402-407.
- Grady D, Rubin SM, Petitti DB, et al. Hormone therapy to prevent disease and prolong life in postmenopausal women. *Ann Intern Med* 1992; **117**: 1016-1037.
- Office of Population Censuses and Surveys. *Deaths by cause: 1991 registrations*. [OPCS Monitor DH2 92/2.] London: OPCS, 1992.
- Lancaster T, Surman G, Lawrence M, et al. Hormone replacement therapy: characteristics of users and non-users in a British general practice cohort identified through computerized prescribing records. *J Epidemiol Community Health* 1995; **49**: 389-394.
- Matthews KA, Kuller LH, Wing RR, et al. Prior to use of estrogen replacement therapy, are users better than non-users? *Am J Epidemiol* 1996; **143**: 971-978.
- Hemminki E, McPherson K. Impact of postmenopausal hormone replacement therapy on cardiovascular events and cancer: pooled data from clinical trials. *BMJ* 1997; **315**: 149-153.
- The Writing Group for the PEPI Trial. Effects of estrogen or estrogen/progestin regimens on heart disease risk factors in postmenopausal women. The Postmenopausal Estrogen/Progestin Interventions (PEPI) Trial. *JAMA* 1995; **273**: 199-208.
- Falkeborn M, Persson I, Adami H-O, et al. The risk of acute myocardial infarction after oestrogen and oestrogen-progestogen replacement. *Br J Obstet Gynaecol* 1992; **99**: 821-828.
- Psalty BM, Heckbert SR, Atkins D, et al. The risk of myocardial infarction associated with the combined use of estrogens and progestins in postmenopausal women. *Arch Intern Med* 1994; **154**: 1333-1339.
- Grodstein F, Stampfer MJ, Manson JE, et al. Postmenopausal estrogen and progestin use and the risk of cardiovascular disease. *N Engl Med J* 1996; **335**: 453-461.
- Newnam HH, Silberberg J. Women's hearts are hard to break. *Lancet* 1997; **349**: s13-s16.
- Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormone replacement therapy: collaborative re-analysis of data from 51 epidemiological studies of 52 705 women with breast cancer and 108 411 women without breast cancer. *Lancet* 1997; **1047**: 1059.
- Rizzoli R, Bonjour J-P. Hormones and bones. *Lancet* 1997; **349**: s120-s123.

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# Medicine and the arts: let's not forget the medicine

There has been much talk recently in medical publications of the role of the arts and humanities in medicine. This discussion has focused largely on the perception that doctors have become less 'humane' in their approach to patients,<sup>1</sup> and that the scientific aspects of medicine in evidence-based practice are now outweighing the personal. In a recent issue of the *BJGP*, Dr Malcolm Rigler gave an eloquent and appealing account of his medical practice in Dudley.<sup>2</sup> He points to this sense of concern in the profession (and particularly in general practice) about our relevance in the context of the ills of modern society and proposes a direct use of the arts in medical practice as an answer. The Chief Medical Officer (who has a personal interest in the arts in medicine)<sup>3</sup> chaired a meeting of interested parties at Richmond House in December 1996. At this meeting, three main groups of people with interests in different applications of the arts in medicine were identified: those who were using the arts in therapy; those who saw a role for the arts in community schemes involving health promotion; and those (mostly university-based) who wanted to see more arts and humanities courses in the education of medical undergraduates.

The education group differs from the first two in its focus on *practitioners* and the *manner* of their practice rather than on the *recipients* (patients) and the *content* of the therapy they receive. This is an important distinction and is central to the discussion of the role of the arts and humanities in medicine. The distinction will become clearer if we look at the fundamental question that

Rigler poses in his paper: 'What does it actually mean to practise good medicine?'

Rigler's answer is that good medicine is anything we can do to alleviate people's suffering, whatever its cause. Others in the profession have attempted to answer this question by producing statements of 'core values'.<sup>4</sup> Indeed, there has been an outbreak of 'core values' statements from medical schools as they attempt to redefine the end product of the educational process. The problem with both answers is that neither seems to say much about practising medicine.<sup>5</sup>

So what does it really mean to practise good medicine, and what part might the arts play in enhancing this practice? The problem in answering the first part of this question is that the practice of medicine involves so many different activities that an all-embracing definition is difficult to establish.<sup>6</sup> It might help here to turn to the philosopher Plato, who classifies medicine as a *techne*, i.e. a craft in common with other crafts, such as cookery, bricklaying, or navigation.<sup>7</sup> For Plato, the good doctor is 'good at' something, and that 'something' is benefiting people in matters of health, in the same way as the cook is good at supplying flavour to our food or the navigator is a useful person to have around on a sea voyage. Being a doctor involves the exercise of specific skills relating to treatment and diagnosis. It may be that the doctor has to try to offer advice relating to personal problems, but this is not part of the skill of the physician. This aspect of a doctor's role (particularly the general practitioner's)

is demanding more time because of the increasing medicalization of society:<sup>8</sup> doctors are being called upon to deal with *all* human ills whether they relate to health or not. The problem with this approach is that the role of the doctor becomes so diffuse as to be almost meaningless, and the task of designing education for such a role becomes impossible. The result of making the attempt is an educational process totally devoid of rigour.<sup>9</sup>

Turning to the second part of my question (what part might the arts play in enhancing good medical practice?), I think most doctors would agree that Plato's view of medicine as merely a *techné*, a skill like cookery or bricklaying, is a necessary but not sufficient view of their art. Unlike cookery or bricklaying, the materials on which a doctor works are human beings, and this means that the practice of medicine must be more than a technique; it involves the exercise of *phronesis*, or practical wisdom. Human beings, unlike bricks, are all different, and their experiences of health and illness are likewise unique. This means that the doctor cannot blindly exercise his skills in the same way with each patient. Rather, he must assess what is appropriate in each situation; and this assessment involves the exercise of practical wisdom. It is in this context that the arts may have something to say to doctors. Well-written plays, poems, and novels can enhance our understanding of the human condition and deepen our sympathies towards those who suffer through it.

Some of us concerned with medical education would argue that a study of the arts and humanities should have a role in helping to form the minds and sensibilities of future practitioners. There are really three points here. First, applicants to medical schools should be encouraged to include in their qualifications some evidence of study in the arts. Scotland has been better placed here in its tradition of a broadly-based secondary education in which pupils are able to take a range of subjects in their Higher exams. In the United States, medicine is regarded as a postgraduate degree and undergraduates are expected to take arts subjects even when they are majoring in science or pre-medical subjects. The second point is a related one. Those involved in the selection process for medical schools should be urged to look favourably on students who have combined studies in both science and the humanities at secondary school; there is evidence to suggest that such students perform better at qualification than those with a more narrow educational base.<sup>10</sup> The third point relates to the content of medical curricula. The General Medical Council has recommended that arts and humanities subjects should have a role to play in increasing the educational value of the medical degree.<sup>11</sup> In these new courses the time spent on accumulating factual knowledge is reduced and there is greater emphasis on preparing students for the practical and emotional job of being a doctor. Curriculum time is freed for what will be known as special study modules, and some universities are using these to allow students to study literature, philosophy, and history.<sup>12,13</sup>

We must not, however, become unfocused about the job of being a doctor or about the training of future doctors. Medicine is, above all, a practical job with a knowledge base that must be acquired and sustained. A background of study in the arts and humanities and the opportunity to study these subjects in medical courses should influence the way in which future doctors practice, but it should not become a substitute for knowing their medicine and delivering good medical care. Professor Anne-Louise Kinmonth, in a recent conference paper, concluded that a randomized controlled trial of 'patient-centred care' for diabetes in general practice resulted in greater satisfaction in the patient-centred group but significantly poorer physical outcome (higher body mass index and poorer diet and exercise profile).<sup>14</sup> We might speculate on the reasons for this, but it is possible that the

doctors were so keen to see patients as people that they forgot to treat them as patients. This role relationship is central to medical care, and a number of benefits spring from it that are not part of a person-to-person relationship. Not least of these is the trust that the doctor will be able to provide an accurate diagnosis and effective treatment for his patient in a humane and respecting fashion.

If, as Dr Rigler suggested, our surgeries become arts centres and our patients artists, where does this leave us as doctors? By all means let us make our health centres visually attractive, but if we lose the role of delivering *medical* care to our patients then the profession will truly have lost its way.

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## References

1. Weatherall D. The inhumanity of medicine. *BMJ* 1994; **309**: 1671-1672.
2. Rigler M. The arts as medicine: a postcard from Withymoor Village. *Br J Gen Pract* 1997; **47**: 684-685.
3. Calman KC, Downie RS. Why arts courses for medical curricula? *Lancet* 1996; **347**: 1499-500.
4. British Medical Association. *Core values for the medical profession in the 21st century*. [Report of a conference held on 3-4 November 1994.] London: BMA, 1995.
5. Macnaughton RJ. Core values: doctor or everyman? *BMJ* 1996; **313**: 120-21.
6. Downie RS, Charlton B. *The making of a doctor*. Oxford: Oxford University Press, 1992. p 31.
7. Plato. *Republic* 332c (ed. Desmond Lee). London: Penguin Classics, 1974.
8. Charlton B. Holistic medicine or the humane doctor? *Br J Gen Pract* 1993; **43**: 475-477.
9. Downie RS, Charlton B. *The making of a doctor*. Oxford: Oxford University Press, 1992. p32.
10. Rolfe IE, Pearson S, Powis DA, Smith AJ. Time for a review of admission to medical school? *Lancet* 1995; **346**: 1329-1333.
11. General Medical Council. *Tomorrow's doctors: recommendations on undergraduate medical education*. London: GMC, 1993.
12. Macnaughton RJ. Special study modules: an opportunity not to be missed. *Med Educ* 1997; **31**: 49-51.
13. Downie RS, Hendry RA, Macnaughton RJ, Smith BH. Humanizing medicine: a special study module. *Med Educ* 1997; **31**: 276-280.
14. Kinmonth AL, Woodcock A, Griffin S, et al. *Diabetes care from diagnosis: a randomised controlled trial of patient centred care in general practice*. Presented as conference paper at the Association of University Departments of General Practice Annual Scientific Meeting in Dublin, July 1997. (Abstract published as conference papers by the Department of Community Health and General Practice, Trinity College, Dublin)

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## Announcement

The 28th British Congress of Obstetrics and Gynaecology (BCOG) will take place from 30 June - 3 July 1998 at the Harrogate International Centre, UK.

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