

# A taxonomy of general practice

## BACKGROUND

Mrs B was 84 years old, when her GP, who had known her for a decade and a half, was asked to see her. Mrs B had been widowed for 5 years, following the sudden death of her husband, Jack. Her two adult sons had been a disappointment to her: both were in and out of prison for repeated minor criminal offences. The practice nurse had asked the doctor to see her, after looking at her blood test results. Below, we show Mrs B's multiple and compounding conditions, and the results of her most recent tests, which sparked the consultation.

### Mrs B's diagnoses

Diabetes  
Hypertension  
Osteoarthritis  
Macular degeneration  
Depression

### Mrs B's lab tests

Glycated Hb 9.7%  
BP 180/96  
Cholesterol 8.0  
BMI 29

The doctor rehearsed with Mrs B the abundant evidence supporting interventions to improve all her biochemical parameters. There was evidence, the doctor said confidently, to support changes in her medication, changes in her diet, and maybe, if she felt like it, changes in her lifestyle. Mrs B listened carefully to the doctor, and then remained quiet for a moment. After a while, she spoke. 'Well', she said, 'Jack's dead, and the boys have gone.'

## INTRODUCTION

GPs are clinical generalists, taught to recognise context and respect patient values, aware of their ability to influence patients through the subtleties of their interaction with them.<sup>1</sup> While this is known, much less has been written about

the theoretical principles behind, and implications of, these features of general practice. In this essay, we try to theorise about what it is in the features that is intellectually important and practically relevant. We explore technical general practice, asserting its importance as a versatile and health-economically important commodity. We look at what it means to 'recognise the importance of context' in terms of different ways of knowing about, and gazing upon, the world. And when we discuss the concept of the doctor as the drug, we are driven to speculate on the relationship, within each one of us GPs, between us as people, and us as practitioners. The two, we will argue, are indivisible, and are combined in the notion of personal knowledge.<sup>2</sup> We conclude by drawing up what we hope is a fresh taxonomy for general practice, in three domains, which we have called technical, evidentiary and reflexive. In the essay, we explain why we have chosen to name the domains in this way, and argue that the taxonomy we develop will be

useful for discussion, reflection and teaching. Our thinking has arisen directly over discussion about Mrs B's consultation, described above.

## TECHNICAL GENERALISM

In the NHS, a new contract for general practice has anchored the profession firmly to the narrow spectrum of clinical, evidence-based medicine.<sup>3</sup> Within that contract, a Quality and Outcomes Framework (QOF) identifies 10 of the most commonly occurring conditions requiring systematic care in general practice, which are listed in Box 1.

Presented thus, the QOF confirms the importance, in the delivery of primary health care, of having generalists. Only GPs develop diagnostic and management skills, which ignore the boundaries of specialty practice. Unlike specialists in the NHS, generalists do not discharge patients simply because their problems lie outside the well-defined boundaries of a particular discipline.

But the technical domain of general practice does not simply reflect diagnostic and management skills for the QOF conditions. In developing their unique technical skills, GPs are exposed to illness and disease at a much earlier stage in its evolution. The clinical skills GPs have to develop are as much concerned with the ability to recognise confidently what is clinically normal. Is this ear drum normal, or not? Is the cervix in this young woman with vaginal discharge normal, or in need of urgent referral? Is the abdominal pain in this sexually abused girl primarily gynaecological, or psychological, or both? Is the development of this 8-week-old baby normal? In the space of a single morning surgery, the GP may be called upon to provide advice to patients and their carers on matters like these. And increasingly, they will make these observations in individuals with several co-existing pathological conditions, for which the current body of clinical evidence is feeble.<sup>4</sup>

### Box 1. Diseases identified in new GMS contract.

- ▶ Clinical domains of the new GMS contract
- ▶ Asthma
- ▶ Diabetes
- ▶ Hypertension
- ▶ Stroke, transient ischaemic attack
- ▶ Epilepsy
- ▶ Cancer
- ▶ Hypothyroidism
- ▶ Coronary heart disease
- ▶ Chronic obstructive pulmonary disease
- ▶ Mental health

The range of undifferentiated problems, or non-disease, that the generalist encounters inevitably creates an inherently uncertain environment, in which the generalist calls on an extended set of management skills, using time to reveal the natural course of a problem. This uncertainty is reflected in the relative weakness of the predictive tests of biomedicine in primary care, with its moderately low prevalence of fully developed disease.<sup>5</sup> Indeed, the generalist helps sustain the specialist's expertise by selecting a higher prevalence population appropriate to that speciality.

### EVIDENTIARY GENERALISM

We argue that the two other central features of general practice, set out in our introduction, constitute two further dimensions of generalism, which we have called evidentiary, and reflexive. Let us consider the first of these.

In Mrs B's consultation, what we see is the interplay of two ways of knowing. We see the doctor deploying a biomedical 'way of knowing', and Mrs B replying from her biographical 'way of knowing'. The former is played out in the description of the evidence-based strategies for improving the biochemical parameters. The second is framed by the patient's stunning response, which comes directly from her lived experience.

We have called this dimension of general practice 'evidentiary', to concentrate our attention on the type of evidence that is being used by each participant, in their respective contributions to the consultation described above. The doctor and the patient each use explanations that are created from quite separate types of evidence. The doctor's is based on the biomedical model, predicated on scientific experiments. The patient's emerges from the unique history of her life, which has made her precisely what she has come to be. What we want to stress here is the link between these two different 'ways of knowing', and of 'making sense' of the world.

The doctor's explanatory model reflects a framework of knowledge that arises from the fruits of scientific experiments, regarding that as superior to, and more robust than, the subjective knowledge of lived experience. In turn, this preference betrays a particular view of the world, a single, 'out there' entity, measurable and verifiable. The patient's contribution comes from her unique lived experience. In offering her contribution in this form, the patient is expressing the importance, to her, of knowledge from quite a different source than the doctor's — the figurative knowledge of her own life.<sup>6</sup> This knowledge in turn betrays a different way of gazing upon the world, one in which our knowledge of the world is constructed incrementally and subjectively over time. Here, in this world view, there is much less certainty about the nature of a single measurable reality.

To see why this is important, we need to draw on some basic terms in medical philosophy. Philosophers would précis the preceding paragraph by saying that each contributor to this consultation drew from their respective explanatory model, each of which was based on a different epistemological framework. 'Epistemology' here refers to the nature of knowledge that we create in order to make sense of the world. Now, in turn, the creation of a particular epistemological framework betrays a preference for seeing the world in a particular way. Philosophers call this an ontological view, where the term 'ontology' refers to one's understanding of the nature of the world. So, we argue that, as this consultation swings from biomedical to biographical phases, something really profound, philosophically, has happened. What we see now is a clash of two ways of seeing the world, two ways of knowing it, and two ways of explaining that understanding. The consultation represents, in short, an intersection of two epistemological frameworks.

So what? For us, the importance of this analysis is threefold. First, the analysis allows us to theorise about 'context' at

the philosophical root of that concept. When we recognise 'context', in terms of a patient's unique circumstances, we enter into an exchange where the conversation moves paradigms, and speculates about different ways of seeing the world. Second, the analysis allows us to consider the relationship between these worldviews. Is one inherently superior? Who says? Can the two coexist compatibly? Are there circumstances where one should always dominate? Third, this analysis helps us see this individual consultation as a microcosm of a macro-conversation about the medicalisation of society, where the debate is another illustration of two quite distinct ontological views. Thus, when medical experts advocate the implementation of guidelines that will 'medicalise' three quarters of Europe's population by virtue of their risk of heart disease<sup>7</sup> they are coming from a particular view of the world based on this idea of a single, measurable reality — what philosophers call scientific positivism. And when we talk of reflexivity below, we will see how this involves a passionate understanding of the terms of such a debate, as opposed to an intellectually celibate stance of so-called 'objectivity'. Those who question the validity of that view, asserting the importance of quality of life, do so from a different perspective, which derives from a (philosophically) quite different set of propositions.

### REFLEXIVE GENERALISM

We have called the third dimension of general practice reflexive. Although many practitioners may be unfamiliar with this term, we have chosen it specifically to focus our attention on the concept of reflexivity, which is central to qualitative research methods. Here, reflexivity refers to the importance of clarifying one's assumptions, being self-conscious about one's judgments and inescapable bias, and actively considering the impact of those on the consultations we conduct.

Doctors are just people who happen to have been to medical school. But our medical education does not immunise us from the fears, or frailties of the human predicament. Like anyone else, we assign value to things, and are as capable of responding to a thing of beauty, as to a call for moral duty.<sup>8</sup> We are social beings just like Mrs B, living the socially constructed narratives that depict precisely what our unique lives have turned out to be.<sup>9</sup> In short, we all have our own 'view from somewhere'.<sup>10</sup>

What is at stake here is the profound truth that we personally, and passionately participate in all acts of understanding.<sup>11</sup> The very act of comprehension combines intellectual, and intuitive, or subjective, skills of judgment which are tacit, and influenced by our lived experience. It is these judgments that interweave passion and knowing to create understanding. Doctors often deny an emotional, or passionate dimension to comprehension.<sup>12</sup> But it is intellectual passion that sways our decision to explore one area of our discipline rather than another, which urges us at times to dispute conventional understanding, and which stimulates the debates that identify us as a community of doctors.

What this dimension forces us to confront is the relationship, within each one of us GPs, between the person and the professional self. If we take the philosopher Polanyi's position,<sup>11</sup> we have to accept that the two are indivisible. There can be no truly independent, neutral or, for that matter objective, way of knowing, as passion constitutes an inescapable part of the every act of comprehension. This, then, confers some obligation on the doctor to be reflexive, examining honestly and with humility any assumptions or prejudices, which will inevitably impinge on our clinical practice. We need also to consider introducing doctors in training to this demanding obligation.

## CONCLUSION

We hope that this analysis of general

practice sheds some light on the intellectual basis of our consultations. The technical biomedical direction firmly set for general practice by the QOF is important, and requires systems and processes, which are accountable and transparent. Within this dimension of generalism the patient is seen not as a unique 'self', but rather as a member of a 'group', that is the group of individuals with a particular condition brought together into an experimental cohort, to create the evidence upon which protocols are based. The conventions of science, through whose experiments this type of knowledge is created, tries to minimise the intrusion of subjectivity by a series of conventions that attempt to strengthen 'objectivity'. But, in the same way as we all have our own 'view from somewhere', this aspiration in science runs the risk of creating its 'view from nowhere'.<sup>10</sup>

We argue that our model legitimises the intellectual foundation of consultations, which focus predominantly on the patient as a subject, a 'self', like the doctor, with a view from 'somewhere'. In these consultations, the participants favour uniqueness over population-derived fact, and by so doing, the narrative-based evidence that infuses those consultations is dignified. Our second dimension in this taxonomy helps us explore what it means, at the philosophical level, to follow consultations, like Mrs B's, when they change from biomedical to biographical. The transition that occurs is profound, and asks questions about the nature of the knowledge through which we create our decisions, and asks also what that means for our fundamental view of the nature of our world. And when we conduct these analyses, we do so within the confines of our uniquely subjective worlds, as susceptible to fear and prejudice as the next person, but occupying the privileged position of the doctor helping our fellow journey men to make sense of their predicament.

Contemporary healthcare policy in the UK may be destabilising the

circumstances within which primary care is delivered, resulting in a massive change of roles and responsibilities. The human condition does not change. The analysis of general practice we present here accommodates the changing technical demands, but recognises that what endures is important too.

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