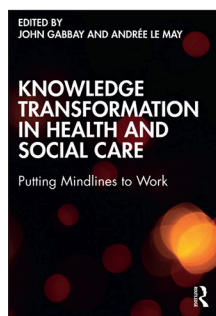


Knowledge Transformation in Health and Social Care. Putting Mindlines to Work

John Gabbay and Andrée le May

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KNOWLEDGE CONSTRUCTION

It's 20 years since the *British Medical Journal* (*BMJ*) sent me a paper to review with the made-up word 'mindlines' in its title.¹ The covering email said something like 'we've already decided to reject this paper but could you please quickly skim it and give us some reasons to pass on to the authors?' I was intrigued. Even the *BMJ* didn't usually reject qualitative research submitted by well-known professors without reading beyond the title. I read the paper and told the editor he should publish it as soon as possible because it described the most philosophically important research study he'd ever sent me. A few years later, a different *BMJ* editor ranked that paper (which has now been cited over 1200 times) among the *BMJ*'s top 20 in the 20 years since the journal went digital,² and in a subsequent *BMJ* poll it was voted the top research paper.

The paper described an ethnographic study of a highly-rated, well-renowned primary-care practice. Two researchers – a doctor and a nurse, respectively, by training, both with an anthropological bent – sat in GPs' surgeries and nurses' clinics and watched the clinicians to see how they practised so effectively. And what they watched was good clinicians not following guidelines. Actually, the GPs and other clinicians did use guidelines – just not in the way the evidence-based medicine playbook assumed (consulting a formal written or online guideline in real time when seeing a patient, for example). So how do clinicians follow guidelines? Let me quote from page 20 of Gabbay and le May's new book:

'Practitioners rely on a wide variety of sources and types of evidence that they must meld together to help them deal with the situations they face. Rather than relying simply on science-based guidelines or other formal, theoretical knowledge, practitioners deploy their knowledge-in-practice-in-context. They rely on their mindlines – flexible, malleable, rapidly accessible, internalised, collectively reinforced, and often tacit guidelines-in-the-head – that they accumulate throughout their careers. [...] The development of collective mindlines is a form of social construction of knowledge, highly dependent on the social relations that shape people's understanding of illness and disease.'

According to this model, the guidelines that matter are not the voluminous 'if X, do Y' instructions produced by the National Institute for Health and Care Excellence or the tortuous algorithms embedded into decision support software – or at least not those sources in isolation. Rather, the things that guide us are the things we know because – to the extent that we are experienced and wise and connected with others in our field – they're in our bones, our jokes, and the unwritten rules that drive our collective ways of thinking and working. We are, individually and collectively, guided by a form of remarkably fast thinking that is long and hard won, and which enables us to care effectively for those patients – often the majority – who are 'exceptions' to the one-size-fits-all evidence-based guideline, and by the stories we share in the spaces in between our patient encounters.

MINDLINES AREN'T JUST INTERNALISED INSTRUCTIONS FOR WHAT TO DO

By the time Gabbay and le May's research revealed this finding (which is startling and reassuring in equal measure), the word 'guideline' had already been taken, so they coined a new word: *mindlines*. Mindlines are not just internalised instructions for what to do. Mindlines are what we share, including the facts we know and the issues we care about. Because of their link to our professional

identity, mindlines are also *who we are*. We collectively get our heads round a new cardiovascular guideline and acknowledge formal thresholds for up-titrating antihypertensive or heart failure medication. But we also collectively understand the reasons for sparing our nonagenarian patients the tyranny of polypharmacy and the medicalisation of their twilight years. We engage with guidelines not as automatons but as *communities of professionals*.

That much was set out in Gabbay and le May's first book in 2011.³ In 2015, Sietse Wieringa and I reviewed the many studies that were based on this rich and intriguing view of clinical knowledge.⁴ Mindlines, it seemed, were everywhere, and explained much of the gap between the evidence-based ideal and the practical realities of clinical practice.

WHAT DOES THIS LATEST COLLECTION ADD?

Mostly, it adds a wealth of detailed examples written by others. Here are some of the highlights. Shout out to my ex-PhD student, dentist Dominic Hurst, who used video ethnography to explore the multiple kinds of knowledge – including the embodied understanding of what enamel and soft tissue feel like through the end of a drill – that are subtly brought into play when your dentist fixes your tooth.

Nurse researcher Kate Beckett and theatre director Tony McBride used forum theatre to create discussions about the complexities and contradictions of people's psychological recovery from major trauma. Theirs were not simple stories with unequivocal happy endings. The dramaturgical form allowed *multiple* knowledges to be surfaced, enacted, and combined, which they then invited audiences to reflect on and so change how they practice.

In a 'situation report from New York City', emergency medicine physicians Edward Suh and Peter C Wyer give a gripping account of how mindlines informed their response to the first wave of the COVID-19 pandemic. At a time of unprecedented pressure on services, a near absence of formal guidelines,

"We are, individually and collectively, guided by a form of remarkably fast thinking that is long and hard won ..."

wretched human suffering, and moral injury among staff, clinicians drew on a multitude of sources including clinical experience, storytelling, social media interactions, and rapidly published research preprints to build and apply dynamic knowledge at the clinical frontline.

Another PhD, by Michael Hodgins, supervised by Ann Dadich and Jane Bye, looked at the role of emotions in the delivery of community-based palliative care. These authors show us how emotions are not separate from our knowledge but part of that knowledge. As one palliative care nurse quoted in their chapter said (on page 78), 'you cannot do your job without emotions'. They reach the intriguing conclusion that in palliative care, 'Mindlines were assembled with emotion as a productive mechanism to prioritise or limit certain kinds of care' (my emphasis).

Who should buy this book and why? First and foremost, people who want a beautifully written antidote to the reductive depiction of clinical practice as rational, algorithm-based decision science. Second, those who study and teach clinical knowledge – especially ye who believe, naively, that evidence-based medicine will serve up most or all of the answers. And, finally, the philosophers among you, who will find, in among the rich accounts of how mindlines have informed and explained effective interventions in a wide range of clinical settings, conceptual and theoretical gems from (among others) Wittgenstein, Polanyi, Heidegger, Dewey, Marx, Schatzki, Garfinkel, and Tsoukas.

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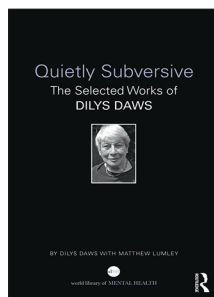
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"Daws quietly subverts our need to make things better and move on, which often makes the consulting room a revolving door."

Quietly Subversive. The Selected Works of Dilys Daws

Dilys Daws and Matthew Lumley

Routledge, 2022, HB, 224pp, £104.00, 978-1032294636



PICKING LOCKS

Why would you pick up a selection of articles by a child psychotherapist you've probably never heard of? In my case it was a combination of editorial charm and the lure of a free book, and I must confess to some initial ambivalence about actually reading it. As it happens, owning ambivalent feelings is something the author encourages.

Just as in war, no plan survives contact with the enemy,¹ we must all at some point come to terms with the messiness of much that happens in our consultations, and the degree to which success in general practice depends not just on clinical knowledge and skills, but on the relationships we form with our patients. Michael and Enid Balint, who highlighted this, were psychotherapists rather than doctors, and much of what Daws writes about child psychotherapy is directly relevant to our day-to-day work. In particular, she argues for the importance of listening without jumping in to try and fix things:

'When families are really listened to ... it may enable them to feel that something crucial about them has been understood ... As they tell their story, unconscious threads draw together and connections emerge ... Most families do not really need more advice. They need to look at the process by which they have found it difficult to use the advice which is freely available.'

I would argue that this applies equally to many of the situations in which we find

ourselves as doctors. Does that resonate with you, or do you feel your hackles rise at all this fluffy nonsense? Either reaction is fine: what matters is 'to note the feelings stirred up in oneself ... and to use these as a source of information.'

Our emotional response to a patient is sometimes the key that tells us what sort of a lock we are dealing with.² A good doctor-patient relationship must go beyond the merely transactional, but the danger in gauging our success at this by how we feel is that we equate a comfortable relationship with one that is effective, and end up colluding with patients we get on with and resenting ones we don't.³ I've noticed in my own practice that a sudden feeling of protectiveness towards a patient can be an indicator of significant trauma in their past. To be helpful in this situation means not just following the feeling and behaving protectively, but considering how to help that person feel safe in themselves.

If you get the chance to read this book, you might be pleasantly surprised. Daws quietly subverts our need to make things better and move on, which often makes the consulting room door a revolving one. The alternative is simply to listen, to our patients and ourselves, with a view to enabling change rather than forcing it. It often feels as if we don't have time, but perhaps less haste, more speed?

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