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A Different Way of Doctoring

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It's good to see so many friends here and I want to do this in a friendly way. I want to stimulate, and I am not particularly interested in provoking. Over the years it seems as if I have fought a lot. When I look back I am not sure whether I ever won or lost, but no fights now. Rather, I would like to share with you some of the ideas and thoughts that have developed over the past 20 plus years that I have been in what might be called academic family medicine.

In particular, I want to talk about a "different way of doctoring," a term I owe to Ian McWhinney. What I mean by "doctoring" is what a generic doctor might do, and I specifically want to talk about general medical care as opposed to specialty medical care. I prefer the term general medical care or general medical practice to "primary care," which I find very confusing and ambiguous. Also, for those interested in semantics, I see the family practitioner, or the board-certified family practitioner, or the pediatrician-internist as "brand names" that have been promoted by vested economic interests or groups. I want to speak not from the perspective of the board-certified family practitioner, maybe not even from the perspective of family medicine (although I am going to try to bring in the discipline here), but from the perspective of a generic doctor in general medical practice.

The care of patients in general medical practice is really a different way of doctoring than is specialty medical practice. Specialty medical practice is the form of medical care that we experience during our medical education and training, the type we encounter in most hospitals and certainly in the academic medical center. I think that we have been well indoctrinated into an internal medicine or a specialty approach. I want to emphasize that what we do is general medical practice; it is quantifiable, teachable, and learnable. First of all, I will explain why there is a difference between a generalist and a specialist; secondly, I will describe and list the principles or the theses behind general medical practice; and finally, I will tell how to do it or the praxis.

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The Difference

The basis for the difference between general medical practice and specialty medical practice is that in general medical practice there is no limitation to the practice. We accept all persons and all problems. We never turn someone away and say, "We can't help you." We realize that we are not able to do all that we would like, and others may have to become involved, but at least we try. We do not have a sign on our door or on our business cards that says "practice limited to diseases of the skin" or "practice limited to neurological disorders."

The consequences of this come about because medicine is a social enterprise. It is socially sanctioned by our society. In fact, our society almost encourages people to be sick and excuses them when they are. As differentiated from most human activities, when one gets sick the cost of care is often paid by means other than one's own assets. Medical costs can be deducted on federal income tax. Illness can be used for disability purposes or explanations for work absences. Also, due to the extensive medicalization in our society and the socially sanctioned place of medicine in our society, many people turn to medicine for help with all their problems. Since generalists do not limit their practices, they see a quite different spectrum of problems from those seen by the specialist. Therefore, the content of the practice we are engaged in is defined not by the physician, but by the patients. We see what the patients bring us to see. The location of the practice and the people who seek our help define the problems we encounter.

Because of our socially sanctioned position, we see a very broad range of problems far exceeding that which might be defined as disease. Most of us who have been in practice realize that more than half the time we can't make a diagnosis in the true sense of the word; that is, we cannot put an etiologic label on the patient's problem.

A consequence of general medical practice is that the problems brought by patients are inherently personal and often undifferentiated. This characteristic provides the opportunity to prevent the continuation of whatever process is making the person sick. The general medical practitioner has the ability to reduce significantly the amount of illness in the population for which she or he cares.

Another consequence is that the problems encoun-

tered in practice mirror the problems in the community. What is common is common. What's not common is not common. It is the epidemiological basis of what we do, and explains the community orientation of general medical practice.

Finally, and this is a real advantage, the practitioner needs no vested interest in any specific technology. As a matter of fact, I think if the electricity were turned off, if we no longer had access to any of the things that we think are now indispensable to medical practice, we could still be successful with at least 85% of what we presently accomplish. These are the consequences of being a generalist and not limiting practice as does the specialist.

What is General Medical Care?

To make this a bit more understandable, let's look at general medical care from the standpoint of game theory. Medicine may be thought of as a science, and that would be true if the task were confined to that which can be studied by the scientific method. It can be considered an art if the practitioner's skills and attitudes are preeminent. It can even be considered a religion if faith in the tangible existence of an abstraction, such as a disease, is required. Finally, it can be thought of as an enterprise if it is seen as a social interaction between the doctor and the patient, analogous to playing games.

General medical practice is like a three-ring circus with three kinds of games going on. If you prefer, you could call these games models of practice. They are the relational model, the clinical model, and the adversarial model. The characteristics of the relational model are those of affinity, evidence of a bond between the doctor and the patient; intimacy, particularly expressed by physical contact; reciprocity, a sharing or a giving and taking between the doctor and the patient; and continuity, not simply seeing the same person for the same problem but developing an expectation that the person is going to be there. It is expressed when somebody says, "That's my doctor," or the doctor says, "That's my patient." There's an expectation that the person will be in the future when you need them. The relational model is the dominant model in approximately 85% of the encounters in general and medical practice.

The clinical model is more the internal medicine model and is characterized by the physician showing evidence of having authority and/or activity. In the clinical model the doctor is active by asking questions, writing prescriptions, doing procedures. The patient is a passive recipient. Doctors are objective or dispassionate in the care of patients and pursue a rational school of thought as they try to help the patient with the problem. The rational school of medical thought includes those things that have been developed from the scientific method in biomedical science. Studies of practices indicate that the clinical model appears to be the dominant model in about 15% of the encounters in general medical practice.

In about 5% of encounters the adversarial model —the doctor and the patient as antagonists—is involved. This type of encounter tends to focus on an entity, frequently a piece of paper such as a disability certificate or a prescription for a favored recreational pharmaceutical. The encounter is characterized by brevity and there is frequently evidence of animosity. The doctor is sometimes surprised or angry when he or she encounters this and takes a while to adapt. Finally, legality enters into the situation because of the doctor's socially sanctioned role as a prescriber or as a determiner of disability, etc.

The Theses

If you are going to play games, you need to have rules. The rules of the game in general medical practice, specifically the relational "game," are what I call the theses, or underlying principles of family medicine. I see them as four in number with the first principle being *The Unity of Mind and Body.* The mind and body, while useful distinctions for purposes of discussion, in fact are inseparable. We know intuitively that we are not divisible into a mind on one hand and a body on the other hand. To separate the mind from the body will destroy the person just as water when reduced to its component elements of oxygen and hydrogen is no longer water. "The body is a machine" analogy that stems from the Cartesian position has been extraordinarily helpful in the advance of biomedical science. But just because it has been useful doesn't mean that it is true; when applied in general medical practice, it becomes erroneous and nonapplicable. It is difficult not to separate the mind and the body when using the language of medicine and discussing treatment and diagnosis. We so easily fall into the mind/body dichotomy. Another aspect of the principle of unity of mind and body is that disease is not a tangible item or an entity. Try telling an oncologist that there is no such thing as cancer! That's true; there is no such thing as cancer; or streptococcal pharyngitis, cataracts, or gout. Diseases do not have an independent existence; they only exist as people exist. You can't even talk about "the treatment of hypertension." When we say, "this is how I treat hypertension," one has to imagine that there is some being called "hypertension" that you give hydrochlorothiazide as though it has an existence of its own. One of the worst things that physicians can do is separate the disease from the patient—taking the disease "out" of the patient and expecting the patient to relate to it as something that is not part of him or herself. When the disease is severed, the patient usually develops a dependency on medicine that is destructive. Patients may well lose their ability to heal themselves.

I call the second principle, *The Primacy of the Person.* By person I mean patient, so I am using person and patient interchangeably. Primacy of the person suggests there are individual rights in health care. For example, lucidity is the right to a full and understandable explanation of what the problem seems to be. Another right is fidelity; that is, in giving information and advice, doctors are

noncoercive and understand their own biases. The third right is autonomy; that is, the patients not the doctors decide. In practice, this is easy to say but difficult to do. Think of it! Patients decide what medication to take, what studies to have done, what procedures to do, what specialists to see. The fourth individual right in personal health care is that of humanity; that is, to state that the goal of medicine is not healing but rather the restoration of patient's personhood. Part of the principle of primacy of the person is that in caring for the person the doctor needs to know the person. This is critically important in differentiating the practice of generalists from specialists. The general doctor must have knowledge of the person.

Another characteristic of the primacy of person is the acknowledgement that learning comes from the patient. The patient is the ultimate and best teacher. In teaching family medicine I have observed that clinical teaching needs to be done in the presence of the patient. Corridor conversations, for instance, are useless because the patient is not involved. I am speaking of the usual situation where the trainee has seen the patient and reports the findings to the preceptor. They talk about the various problems, then go in and let the patient know what should be done. This is not family medicine teaching. Teaching should occur not only in the context of patients but in the presence of patients and with their full involvement.

The third principle is that of *Inner Harmony.* This is a Hippocratic concept, adapted by Cannon & Selye.[1] Inner harmony states that healing comes from within the patient and is not something that doctors "do" to patients. We think of ourselves as healers yet the only ones we have ever healed are ourselves. What drives this healing force that Cannon called internal homeostasis? I suspect it is probably hope, and hope is generated by being a free agent in control of oneself. Often people die when they become dependent; they give up control and no longer have this thing (hope) inside that is keeping them alive, so they die. I've had some experiences in the past couple of years in which patients with fatal diseases had been told that they could stop fighting to live. They did that and they died within a few hours. They gave up hope which is sometimes a good thing to do. We all know that our life is limited and there will be a time that we will die. I would just as soon die on a positive aspect of deciding that I do not want to live anymore. I will stop being a free agent and I am willing to give up control. It can work both ways for us.

Given this idea of inner harmony, the physician's task is to try to activiate inner healing. We do this in very highly specific ways with the armamentarium that biomedical science has given to us: antibiotics, diuretics, etc. We can also activate inner healing through general measures. Certainly, all serious researchers are aware of the placebo effect. Giving a pill is a powerful placebo. Touching somebody is a very powerful placebo, as are caring for and loving somebody. I'm not talking about deception. If you prescribe sugar pills, you must say that they are sugar pills. The placebo effect is often neglected although some of the most innovative work in family medicine concerns the placebo effect. Howard Brody has written a beautiful book about it.[2]

The fourth principle is that of our *Social and Biological Destiny.* We, as mammals, need others of our kind to survive in the hostile environment in which we live. The maternal-infant bonding that occurs in mammals is the result of being born alive but not independent. This person to person bond or affinity is the prototype for all future human relationships. This relationship with other people is mediated through physical contact. You might call it the "right touch" because we need to be touched in order to survive. We seek out others who will touch us. In ethology this is called social grooming, and I am sure that a good doctor is a good groomer. In fact, one can't be a good doctor in general medical care unless one is a good groomer.

The Praxis

How are the four principles applied in medical practice? There are observable and quantifiable differences between the generalist and the specialist as they care for patients. These differences can be seen, taught, measured, and evaluated.

One of the differences deals with information gathering. The first contact with the patient provides the opportunity for what I like to call the "veil of ignorance." The veil of ignorance is the need for the physician to understand the motivations and expectations of the patient before the encounter is changed by exploration of the problem. In quantum physics there is the Heisenberg Uncertainty Principle: as we observe we become participants. So, in our contact with patients we want to learn as much as we can about the patient in advance of our participation in the problem. When somebody comes in and says, "I've got this thing on my skin here," we don't take the usual medical approach and say, "Well, how long has it been there? Does it hurt you? Does it bleed? Has it gotten bigger? What seems to make it better? What seems to make it worse?" We don't do that. We pull down this veil of ignorance and try to find out what the reason is for this visit. Why did the person come now? Why did they come here? What are the other options that the person had for care and didn't use? Who else is involved? We also want to know what the patient thinks it is. Is it a cancer? Heart attack? Stroke? Sexually transmitted disease? What are the relationships of this to other people? What are the folk beliefs around this concern that the patient brings to us? What does the patient think this is going to do to them? Is it going to cause disability or sterility? How is it going to affect relationships? How much is it going to cost in time, in discomfort, in disruption, and money? We want to find out what they want from us. What sort of investigations do they expect? What sort of procedures or information are they looking for? Do they want advice and recommendations? What is the whole set of expectations that they bring to us? What is their

perception of their current health status?

A good doctor in general medical practice will start off trying to get information about the patient that is quite different from the conventional approach to medical history. We want knowledge about the patient's origins and background. What are the roots, childhood, family relationships (a genogram), ethnographic background, and spiritual beliefs? What social and health problems have existed in the past? What is the current situation in terms of relationships, habits, nutrition, personal finances, housing, and occupation? What does the patient think of the future? What are the plans and expectations? What are the possibilities? We attempt to gather information about all of these things moving on to the clinical problem. This need not take long as much of this is an attitude of how you present yourself to the patient.

The second part of the observation of and communication with the patient is the examination. We don't pay enough attention to the physical examination. The examination is so important in the care of patients and yet it is ignored more than history taking. First of all, it gives us a chance to groom the patient: hold his/her hand, remove ear wax. Sit and watch "good" GPs; they can't keep their hands off the patient. In the book *Family Medicine: The Medical Life History of Familes*[3] Huygen talks a lot about ear wax. The removal of ear wax is a good example of grooming our patients. I think grooming in a sense is simply skin care. It is a caring type of activity. Examining the patient gives us the opportunity to embrace the patient. We can become very intimate when using the ophthalmoscope. A good doctor is a good groomer. Do you know how to tell a good O.P.M.D.? (O.P. is an older person, M.D. is a medical doctor.) A good O.P.M.D. carries around a heavy nail clipper in his or her pocket. One of the tasks that a good G.P. can do is to cut toenails. As we age we have trouble getting down to our toenails. Also, toenails get much thicker. One way to mobilize the placebo effect is to clip patient's toenails.

The second reason for the examination is to involve the patient as a participant. Patients can learn how to take their blood pressure; women can learn how to examine their breasts; men can learn to examine their testicles. Women can enjoy the pelvic examination because they can participate in it. Women can be part of the examination when the examiner's hand is in the vagina and they can feel their own uterus and can use a mirror to observe the cervix.

Another aspect of the examination is to confirm to the patient that we are skilled practitioners of medicine. We know how to use our tools and that we can use our tools without hurting them: we can look into the ear without damaging the ear canal; we can do an abdominal examination that is not painful; we can do a genital examination that is not embarrassing or degrading; we can do a rectal examination that does not hurt. Those things really help the doctor-patient relationship and confirm that it is our social and biological destiny that we need other people to care for us. Also, a physical examination may provide some information about the patient's problem.

Part of our evaluation should be a statement about the functional health status of the individual. We need to list our opinions on a probabilistic rather than a "rule out" or deterministic basis. In our evaluations, we list the various options of caring for this problem and the risks and benefits of each, and then the patient decides which to do. One of the options is that patients can always do nothing. Another option is go to another doctor. There are generally two or three other options and one of those may be according to what I know and what most medical authorities say is the preferred treatment. It's amazing how often patients don't want to go along with the opinion of the best medical authorities. They have their own idea about themselves and their health and what they want to do. One problem is that it may conflict with our own ethical or personal values. Then it is necessary to say, "I can't do that. If that's the option that you wish to pursue then I suggest maybe we find another doctor. I will help you locate another."

Next we come to the continuation of care. Agreements and contracts are useful. William May in *The Physician's Covenant*[4] prefers the idea of a covenant between the doctor and the patient; a promise on the part of the doctor rather than the pure economic contract. Both parties in this, the doctor and the patient, work toward the same goal and agree to do certain things.

The final thing that needs to be done in the practice is something that we rarely do: predict an outcome of the problem. We've stated probabilistically what we think the problem is, and now we need to think about the individual's future functional health status. For example, someone comes in with a basal cell carcinoma on the skin; it is taken off; the prediction is that it will completely resolve, will not recur and the patient's functional health status will not change. If one begins to do this, one rapidly finds out that doctors are not very good soothsayers. We don't know that we are wrong unless we predict the outcome when we treat the patient.

I have tried to describe a different way of doctoring, much of which is an attitude upon approaching the patient. It is different from the approach of the specialist, and is the approach I think is most appropriate in general medical care and the discipline of family medicine.

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