OCCASIONAL PAPER 65

What is Good General Practice?

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What is Good General Practice?

A Philosophical Study of the Concept of High Quality Medical Care

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Charter

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Editor's Preface

THE pressure of day-to-day general practice has never been greater and the pressures on the doctor in the consulting room, coming as they do from the growing range of the work, the increased responsibility and the growing number of external pressures, makes time an ever more valuable commodity in primary care. William Davies' famous words "What is this world if, full of care, There is no time to stand and stare?" seem increasingly remote from the hurly-burly of three-hour surgeries and late home visits.

Against a background of pressure and pace it is therefore particularly important for general practitioners to organize their lives in such a way that there is some time when they can indeed "stand and stare" in a professional as well as personal sense. In the real world of 1994, sitting and thinking or talking together in groups is probably the most effective form of "staring" professionally.

At a time when there is increasing interest in personality factors and their relevance to medicine and to education, Lewis and Bolden (1989) have shown the importance of learning styles and personality types in the professions, especially among general practitioners. General practitioners as a group are more likely to be "pragmatists" (Honey and Mumford, 1986) and perhaps relatively less likely to be "theorists". Similarly Isabel Briggs Myers and Peter Myers (1980) have shown that general practitioners are more likely to be in the extrovert ESTJ or ENFP categories rather than say abstract thinkers (INTJ or INTP).*

Despite being the largest branch of the medical profession, general practice has been relatively short of theorists who can think deeply about the nature of medicine and the place of general practice within it. When it does produce theorists like Fry, Tudor Hart, Marinker, and McWhinney they stand out as having produced ideas of international interest and applicability. The Bible assures us that "where there is no vision the people perish" (Prov. 29:18), yet vision is hard to come by, especially in times of rapid change.

Occasional Paper 65 is a discussion paper which is certainly not easily read but which we hope will enable colleagues to stand back and think about the nature of medicine, especially in general practice.

Dr Peter Toon, writing from the Department of General Practice at the Medical Colleges of St Bartholomew's and the London Hospitals, takes as his starting point the fact that doctors are taking decisions all the time and that these are particularly important to analyse in the most open-ended field of all in clinical practice. He therefore tackles the subject under the challenging title "What is good general practice?" and seeks to answer his own question first by discussing the meaning of 'good' and then going on to consider some of the broader issues raised concerning roles and relationships. Throughout this paper Dr Toon contrasts the biomechanical or biomedical models of medicine with some of the alternative frameworks, including the Balint movement (1957) as well as the anticipatory or preventive care models. He deals with aspects of the doctor-patient relationship, especially the question of autonomy and whether or not those who seek care from general practice should be seen as patients within a medical framework or consumers of a business. He also discusses the role of the family and family medicine as one aspect of general practice.

Not all Dr Toon's analyses will be familiar; his contrast between teleological and hedonic models in Chapter 5 takes his analysis into existentialist thinking — and there will be few general practitioners who will not need to pause and reflect on the implications of some of these ideas.

At a time when so many assumptions about health service planning and medical management are made in the documents currently being disseminated within the National Health Service, it is helpful to stand back and think whether disease can be separated from the patient and be externalized as in some forms of surgical treatment, or whether illness is in fact more appropriately seen as part of the whole person. Profound implications for the need for care and medical organization follow.

This is not a booklet which sets out to provide any easy answers: those who look for these will be disappointed. It is, however, a text which challenges, probes, and questions, and at times illuminates as well. In this way it fulfils one of the criteria for continuing education.

Denis Pereira Gray
Honorary Editor

April 1994

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* ESTJ Extroverted thinking with sensing
ENFP Extroverted intuition with feeling
INTJ Introverted intuition with thinking
INTP Introverted thinking with intuition

Acknowledgements

THIS work has had a long gestation period and it is difficult to remember over so many years who has sparked off ideas and comments which have contributed to the final result.

Much of the work was drafted on a sabbatical visit to the Bioethics Research Unit, University of Otago, Dunedin, New Zealand. I am most grateful to Alistair Campbell and Grant Gillett for making me very welcome in that Unit, and to the members of the Department of General Practice at that University and their then Head of Department, Professor Campbell Murdoch, for their support and encouragement as well as their hospitality. Thanks must also go to the Department of Health for granting me prolonged study leave for that sabbatical and to the International Committee of the Royal College of General Practitioners for a contribution towards my travelling expenses.

Pre-eminent amongst the many who have encouraged me and given helpful comments are Len Doyal, who helped me to formulate my question, which is always the hardest part of any research project, and Gene Feder, who loyally struggled through a less coherent draft and gave me invaluable comments. Thanks are also due to Jeannette Naish and Richard Bennett whose comments on the draft were also most useful, and to Sarah Divall, Roger Higgs, Sheila Hillier, Malvin Salkind and Lesley Southgate, who supported me during the first trimester of the gestation of this work.

I would, however, like to dedicate this work to the general practitioners of Hackney and Tower Hamlets, whose excellences have demonstrated to me the rich diversity of good general practice, which cannot and must not be forced into one rigid mould.

PDT

Preface

AFTER thirty years of steady progress, general practice in the United Kingdom is seriously afflicted by anxiety and uncertainty. A period of evolution and internally motivated development seen as positive by most practitioners has been followed by an era of externally imposed and revolutionary change to which the majority are hostile. The new general practitioner contract of 1990, rapidly followed by the NHS reforms in the hospital service and the advent of general practitioner fundholding, has replaced what seemed like eternal certainties by shifting sands and uncertainty over the future direction of general practice.

The apparent confidence of a Government which wants to increase the power of general practitioners through fundholding, and has put the central responsibility for prevention on general practitioners working with individuals, has not compensated for the imposition of a more rigid contract with additional duties and increased constraints. Faced with such rapid changes and doubts, morale amongst general practitioners has plummeted and recruitment has suffered (Jebb, 1991).

There are also wider social influences at work. The continuing problem of cost-containment in health care is having an increasing effect on day-to-day practice. Longer standing issues such as the debate over the value of high technology medicine, the difficulties raised by working in a multicultural and pluralistic society, and increasing expectations and demand coupled with a fall in the relative status and financial rewards of general practitioners fuel dissatisfaction and disillusion. These feelings were demonstrated in the results of the survey conducted by the Electoral Reform Ballot Services on behalf of the General Medical Services Committee (1992) on the future of general practice.

Although discussion of how general practice should develop and how we define good practice and quality of care is not new, in such a period of rapid change every structure and institution become open to question and the debate quickens. There are strongly held and widely differing views on how general practice should react. Which of the changes are positive and which are threats? Which aspects of the traditional ways are central and must be held on to at all costs, and which are no more than comfortable habits? What is the best way forward?

Debates are often fierce both within and outside the medical profession, but are notable more often for the heat which they generate rather than for the clarity and coherence of the arguments. The main reason for this, I believe, is that the argument is conducted on the wrong battleground. Whilst discussion centres on political and structural matters such as the use of deputizing services, the 24-hour commitment, the independent contractor status and the contractual structure for health promotion, the real differences concern views on the aim of medicine, the nature of the doctor-patient relationship, and ultimately the purpose of life. These problems are very real, but the argument has to be conducted in philosophical, not political or scientific terms. To do otherwise is like trying to design a skyscraper from the first-floor upwards, without paying attention to the foundations. Although those involved in the debate may have the foundation of a deeply rooted vision, it is not expressed overtly in the debates. Since the basis of the arguments of those conducting the debate differ, views on strategy and tactics are bound to be irresolvable.

The aim of this work is to excavate those foundations by analysing in philosophical terms the question: "What is good general practice?" I shall argue that the key to understanding debates about quality in general practice is to recognize the distinction between questions of fact and of value. These are closely intertwined in medical judgements, which often leads to confusion. Values are more fundamental to matters of medical judgement. Their discussion is part of the philosophy of medicine, closely allied to other areas of medical ethics. This is not more widely recognized because of a belief that only matters of fact can be the subject of rational analysis, by the scientific method and matters of values are entirely subjective and not worth discussing. This view is, however, misguided. First, there are strong arguments against moral relativism. Secondly, even if one accepts the relativist position, philosophical analysis can help by ensuring clarity and coherence of philosophical positions. The bulk of the work is devoted to attempting the latter task.

Three models influencing general practice

Study of general practice writers reveals that there are a number of different models and philosophical views which can be seen to influence general practice. I will define three main models. The biomedical model is the basis of scientific medicine and is an Enlightenment product. The teleological or humanist models express a different and older philosophical tradition. I will take the Balint movement as a particularly clearly developed and British example of these models. The preventive or public health model provides yet a third set of philosophical assumptions.

Philosophical analysis reveals that each of these has different values and metaphysical assumptions. The models are not reconciled because they are not recognized, which explains much of the interminable debate about the organization and priorities of medical care.

Two other issues which may affect our notion of good general practice must be considered. The first is the business basis of general practice, with the consequence that patients are also in some senses customers. In all types of medical practice there is a tension between professional altruism, or "moderated love" (Campbell, 1984), and the practical necessity of earning a living. In general practice this finds its particular expression in the conflict between being a successful small businessman, responding to consumer demand, and acting for the patient's good when these two are not identical. This is a real problem which has to be addressed alongside the conflicts between the models already discussed.

The second issue is the place of the family in family medicine. In contrast to the reality of the business nature of general practice, the concepts of the family and family practice are revealed as mirages — solid and substantial when viewed from a distance, but dissolving into thin air when examined more closely. General practice and family doctoring are for all practical purposes identical, and it is seen to be impossible to base a philosophy of general practice on ideas about the family.

We are therefore left with our three models and the practicalities of how to act rightly in a material world of limited resources. The final chapter considers whether and how these models might be resolved. Despite its lack of an articulated coherent philosophical basis, general practice has flourished as a profession and an academic field for many decades. Recognizing the inconsistencies in our enterprise is essential, but the difficulty in their resolution should not make us despair, any more than we would abandon the scientific search for empirical truth merely because research is difficult. Although at this stage it is not possible to provide a unified philosophy of good general practice, this work reveals an agenda of issues to be resolved in order to define such a philosophy. In the meanwhile a suggestion is made about how quality issues can be addressed immediately without philosophical incoherence.

Underlying values

The purpose of this book is to reveal the values which underly our judgements, in the hope that doing so will enable arguments to be conducted in a clearer light. It will not resolve all controversy, since there is no consensus on fundamental philosophical premises. It may, however, help people to argue more clearly about real differences rather than peripheral matters.

This therefore is essentially a work of medical ethics, but of a rather different type from those to which many readers will be accustomed. Medical ethics has traditionally focused on 'major issues' involving choices which make a large difference to individual lives, often indeed being 'matters of life and death'. General practice ethics has been comparatively neglected, the moral issues being seen as less important. This is, however, mistaken.

There does not exist a scale on which to measure the significance of moral judgements nor would it help to try to construct one. There are, however, more general practitioners than any other type of doctor, and many more individual contacts with general practitioners than with other clinicians. The cumulative impact of the many decisions made by general practitioners is enormous, even if the difference each of them makes is small. The consequences of these decisions are at least as great as of those in areas such as neonatology, *in vitro* fertilization and genetic engineering, which have attracted lengthy conferences, symposia, and royal commissions but actually affect few people.

This is not intended to be a work of medical history but an examination of concepts of good general practice which are currently influential. Since our present situation derives from our history, some consideration of past events and movements of thought is necessary. Those interested in a history of general practice should, however, refer to specialist works on the subject.

Some readers may feel that we should be considering the nature of good primary health care rather than good general practice. However, despite the development of the primary health care team, our structures still place general practitioners at the heart of the team and often make them its leader. Although this may, and I believe should, change we will continue to need primary medical care amongst the other facets of health care. In the discussion which follows, the term 'general practice' could often be replaced by the term 'primary health care team'; and what I have to say about the individual practitioner applies equally to the team. I make no apologies, however, for concentrating on the role of the general practitioner, since as a general practitioner myself I can only write from that perspective.

CHAPTER 1

Why ask the question?

Introduction

'QUALITY of care' is a phrase often used when discussing our vision of good practice and how near (or far) we are from it. Views of what are acceptable minimum standards and what goals should be depend on our concept of good practice. The question which forms the title of this work could equally well be: "What is quality in general practice?"

General practice is an open-ended field of clinical medicine without clear boundaries in which there are many judgements to be made. Doctors make decisions all the time in the privacy of the consultation, and individual practices and family health services authorities make decisions on policy which affect health care. Bodies such as the Royal College of General Practitioners, the Government, patient organizations and other pressure groups, as well as those directly involved in providing care, have perceptions of good general practice which cover both levels of judgement.

This is, however, only half the discussion. The structure under which general practice operates is not immutable, as those who have lived through the upheavals of recent years know. It is unlikely that recent changes will be the last, and the structure of primary care will remain on the political agenda for some years. Other countries have very different ways of organizing services. Medical care can be provided by private charitable institutions, as formerly in this country, funded by a compulsory State-run insurance system as in France, or paid for by private health insurance, as is largely the case in the USA.

Boundaries between primary and secondary care and between generalists and specialists can be drawn in different ways. For example, in Russia most care is provided by specialists working in polyclinics, with generalists playing a much more minor role. Many people in the USA receive all their medical care from specialists, although in both cases this seems to be changing (Russian Ministry of Health, 1992; Graham, 1993). One strand in the Tomlinson Report (1992) was the transfer of work and resources from secondary to primary care. How can one decide whether foreign ways or our ways, old ways or new ones, are better? We need a clear concept of good general practice if we are to make sound judgements in these political debates.

If we wish to set standards for entry and for continuing accreditation in general practice, or to reward those who provide good care, we have to be clear what the basis of those standards should be. If we wish to change the way in which general practice and primary care are organized, this implies an ideal which we are seeking to achieve: an image of good general practice. Which structures we favour and the vision which underlies them will determine our view on issues such as whether we reward teamwork or emphasize continuity of care; whether we slant payments towards promoting prevention or towards smaller lists. Therefore our attitudes to general practice contracts and payment systems also depend on our view of good general practice. A concept of good general practice is implicit in the actions of a wide variety of individuals and groups. Although views are rarely stated overtly, these would be impotent without them.

The doctor with the patient

General practitioners continually make decisions on how to spend time and which investigations or treatment to advise. Perhaps two cases which are fairly typical and not obviously dramatic will illustrate the problem of deciding what is the best care in everyday practice:

Case 1

The doctor is asked to visit a 79-year-old man after evening surgery. The message is rather vaguely that he is "not himself". Although this does not sound urgent, he does not usually request visits without good reason and is not in good health, and so she goes to see him immediately.

The man is well known to her, having been her patient since she joined the practice. He has long-standing rheumatic heart disease, and more recently angina. He had an episode of acute left ventricular failure one night a few months ago, but did not call the doctor until the next morning. He also had a rather stormy course following a prostate operation 18 months before.

On arrival the doctor finds him in bed looking pale, sweaty, and rather unresponsive. She has difficulty finding his pulse and wonders if he has had a heart attack. His wife, however, is quite clear that he has not had any pain but says that he has not been well all day. She is unable to pinpoint any specific symptoms except that he told her this morning that he "thought his time was up".

After a minute or two he perks up and starts to talk, and the doctor wonders if he merely has a viral illness. A strong pulse is easily felt. Chest, heart and blood pressure examinations are all normal.

The doctor has to decide what to advise. The right course of action is by no means clear. If she sends the patient to hospital to exclude a heart attack it will involve him in unpleasant tests and treatments, and a frightening and strange environment which she knows will distress him. If hospital treatment will not affect the outcome, his wife and family may prefer to care for him at home, and he may be happier and more comfortable there. Admission will commit resources:

ambulances, investigations, nursing care and drugs, which may deprive others of those resources from which they may gain more benefit than this patient.

On the other hand if the doctor keeps the patient at home, is she depriving him of treatment for a serious or even fatal illness? Although old and in poor health, he could live for several more years, even after a heart attack. What should be done?

Case 2

A 17-year-old youth tells the nurse that he missed his BCG at school and needs to be tested. She therefore does a Tine test and asks him to return to the doctor to have it read three days later.

The doctor knows him well. He lives with his mother, a pleasant healthy woman in her early fifties, his father who is now well four years after a renal transplant, and his three-year-old brother.

The test is borderline grade 2/3, with erythema around each spot almost but not quite touching. What advice does the doctor give?

Clearly the young man should not have a BCG, but should he have a chest x-ray to exclude active tuberculosis? If a chest x-ray is not done, there is a small but real risk of tuberculosis being missed. It may progress and he will be more ill than he need have been. Also he may infect others, particularly his immunosuppressed father.

All this is very unlikely, however, and a chest x-ray costs the NHS money. It will inconvenience him to go to the hospital and he may have to take time off from work and lose money. The radiation risks of exposure to a single chest radiograph, although small, are measurable. The doctor almost unconsciously balances the pros and cons of these factors in deciding what advice to give.

These cases illustrate the variety of issues involved in choosing the best course of action even in apparently simple clinical decisions. Most doctors most of the time do not consider these factors consciously; to attempt to do so would make life impossible. Instead they act on unconscious or semi-conscious habits and assumptions; the principles of what they believe to be good practice. This is not necessarily a bad thing. St Thomas Aquinas in *Summa Theologiae* defined virtue as "the habit of acting rightly according to reason". The desirability of acting in this way depends on whether the habit is right or wrong and whether it is guided by sound reason. Whilst acting according to habit is essential in our day-to-day work, we should take time to examine these assumptions to make sure that they are consistent and coherent according to reason, and that they represent our true values.

Good practice policies

Under our present system, doctors and practices make managerial decisions about priorities and strategies to achieve these goals as well as decisions with individuals in the consultation. General practitioners are responsible for providing health care to a group of people on their list.

Until 1990 NHS general practitioners were required by their Terms of Service (in effect the standard contract between the Government and the individual doctor) to provide "general medical services". These were defined as "those services generally offered by general medical practitioners" — surely one of the smallest circular definitions ever! They were also paid by the NHS for the provision of other medical services — maternity, contraception, immunization and cervical cytology. These were optional, although in practice most general practitioners offered them. By arrangement with individual patients and other bodies doctors could also offer some non-NHS services to NHS patients, such as medical examinations, reports and various forms of certificate. Again they were not compelled to do so, although in practice most did, despite some controversy (Toon, 1992).

The 1990 contract added a specific defined list of "health promotion" duties: annual visits to the elderly and "health checks" three-yearly for non-attenders. New item-of-service payments were introduced for health checks for new patients and for a defined list of health promotion clinics, minor surgery and paediatric surveillance, although these were not compulsory. Target payments replaced item-of-service payments for many immunizations and cervical cytology, although whether a doctor was compelled to offer them was not quite clear. With the introduction of health promotion "banding" instead of the clinic system and three-yearly checks, the situation has changed again and will no doubt continue to be fluid.

Despite these new statutory duties there is still a wide freedom of choice for the individual practice. While one offers annual checks to all its diabetic patients, another may refer them to hospital. Some practices give priority to performing minor surgery, whilst others devote time to counselling patients with psychological distress related to life events. Some may choose to put a lot of energy into achieving target payments; others may opt for a larger list, or top up NHS earnings with private work such as medical examinations.

Not only do practitioners have wide discretion in deciding what care to offer, they have flexibility in how they offer it. The general practitioner is contracted to provide a health care service for 24 hours per day every day of the year, but this service need not be provided personally; indeed it would be exceptional if it were so. General practitioners may combine in groups and/or sub-contract some care to assistants, locums and deputizing services. Choices between these options have provoked some of the fiercest controversies in general practice, recently summarized by Williams (1993).

Moreover, it is not just doctors who provide health care in general practice. Receptionists, secretaries and practice managers are now a standard part of the primary health care team. Bowling and Stilwell (1988) discuss how clinical duties are shared with practice nurses in the majority of practices, and one of the features of the 1990 contract was to widen the spectrum of health care professionals who could be employed in the practice (DoH, 1990; para 52). Defining good general practice includes setting standards for the quality of those services and the way in which they function.

The priorities of the practice team will to a considerable extent determine the type of service which it offers to its patients, and how this is organized. The spectrum of choices which general practitioners and their colleagues are called upon to make extends from the minutiae of the consultation to the strategic planning of the practice.

The statutory authorities

Although many policies and priorities are determined in individual practices, family health services authorities have considerably more input than their predecessors, who were concerned primarily with payment and administrative structures. For example, they can set local priorities within national guidelines, their decisions depending on the sort of practice they wish to promote, which again may often be only partly conscious or articulated.

Government pays for general practice and so has views on what it wants for its money. The view of the Government of the time is particularly clear when the contract under which general practitioners operate is changed. The debate at the time of the General Practitioner Charter in 1966 has been described by many medical writers, for example Tudor Hart (1988). The debate in 1990 has not been so thoroughly analysed but the principal documents and ephemera are still widely available and are awaiting the attention of medical historians.

It seems that in 1966 general practice was perceived to be limited by a contract which not only failed to encourage the development of services but financially penalized those who did so. Dissatisfied general practitioners were emigrating in large numbers. General practitioners proposed a set of reforms to remedy the situation. The elements of the Charter which were accepted — payments for improvements in premises and in staffing, and to encourage specific services such as cervical cytology and contraception — reflect the political philosophy of the day. Good practice was seen largely in terms of better premises, better administration, appointment systems, and expansion of services such as cervical cytology and contraception.

In 1990 the situation was very different. Although general practitioners had been asking for changes in their contract for some time, they did not like the Government's proposals. Some changes, such as the introduction of special payments for doctors working in deprived areas and a fairer cost-rent scheme, were generally welcomed, but others were fought vigorously. The Government sought to increase competition amongst general practitioners and to promote the free movement of patients in accordance with their market philosophy. It therefore made it simpler for patients to change doctors and tried to increase the proportion of the doctor's income dependent on the number of patients on the list.

The Government also seemed to want firmer control over general practice and introduced new regulations stipulating precise clinical duties for the first time in British general practice. In order to develop the preventive role it introduced target and health promotion payments and stipulated preventive procedures which doctors were required to carry out. These activities were criticized by doctors as representing an unscientific waste of resources which interfered with dealing with the problems presented by the patient and were damaging to the doctor-patient relationship. Such changes, being perhaps more in tune with lay perceptions of good practice, were criticized less by patient organizations and in population surveys.

These actions demonstrate the importance of the Government's views of good general practice. The conflicts illustrate the tensions influencing government policy, which is always a compromise. Popular perceptions such as the wish for health checks and pressure to be seen to do something for disadvantaged groups such as those in inner cities, women and the elderly combine with a general political philosophy and scientific advice to produce a package not notable for its logical coherence or clarity of goals. The political process more often adds to rather than resolves such muddle and illogicality. Some of the goals are incompatible and the consequence of some of these changes conflicting. As they are subject to these pressures, it is important also for governments and others involved in political decision-making to have a clear and articulated vision of what they are seeking to achieve, if they are to stand any chance of achieving it.

The patient — choosing a good doctor

People moving to a new area will look for a 'good' doctor. What they mean by this varies. It may mean one who is technically highly competent, one who is a good listener, or one who has a pleasant surgery and a well organized system for consultations. Most individuals have some view of what they require from general practice. Health is a central concern of most people and they get more of their health care from general practice than from any other source. Almost everyone is registered with a general practitioner, and the vast majority of people visit one from time to time, about two-thirds doing so each year (Ritchie et al., 1981). Thus most people have some experience on which they can base an opinion.

Comments such as "She's easy to talk to"; "He doesn't listen to you, he just starts writing out the prescription before you even sit down"; "He never even examines me"; illustrate perceptions of good practice. These may not concur with those of the professions or of the authorities. They are not necessarily simple or coherent; witness the patient who, having roundly criticized his doctor as unsympathetic, concluded: "Mind you, he's awfully good if you've got something wrong with you" (Murdoch C, personal communication).

In the British system access to most types of health care is via the general practitioner, who acts as a 'gatekeeper' (Mathers and Hodgkin, 1989). Thus it matters to almost everyone that their general practitioner should be good, since if the gatekeeping decisions are wrong it can be hard to obtain more specialized care.

"The general practitioner is ideally placed"

Many people have interests or priorities in health care which they wish to promote. In recent decades such people have increasingly formed self-help or pressure groups (for example, the Asthma Society, the British Kidney Patients Association) in order to benefit from mutual support and get a better deal for their particular group. There are also many professional special interest organizations within medicine. These include both organizations for general practitioners such as BASICS, the GPs in Asthma Group, and the Balint Society, and also organizations for specialties or subspecialty interests. All such groups have their own agenda and often believe rightly or wrongly that general practitioners have a role in promoting this. Because he offers a broad and vaguely defined service, the general practitioner is often

expected to fulfil these special interests. The opening sentences of two articles from recent general practice periodicals illustrate this sort of thing:

> GPs should be more alert to clues of autism, especially when listening to a parent's worries, according to a GP expert.
>
> (*Pulse*, 1992a)

> GPs need to be alert to symptoms of Kawasaki disease, which is responsible for a disturbing increase in deaths of children, according to a new report.
>
> (*Pulse*, 1992b)

Most general practitioners are familiar with this "GP should" syndrome; and the writer who asserts that "all good general practitioners" should provide this service should be more aware of the problem, or should spend more time on a particular issue. Magazines for general practitioners are constantly reporting such statements. Taken individually these suggestions seem eminently reasonable: it is important that general practitioners keep up to date with advances, are aware of new threats, and review the services they offer. Considered together, however, they are overwhelming. We need some way of evaluating these demands and setting priorities, since pressures on an open-ended service are potentially unlimited and insatiable.

The quality debate

Increasingly quality of care is being discussed by professional groups and by individual doctors, as well as by government, family health services authorities and the pressure groups mentioned above. Setting quality standards involves, amongst other things, minimum standards for entry into general practice, for continuing education, and for performance once established in practice. It also involves higher aspirations, measures of excellence to be rewarded by marks of esteem, such as Fellowship by Assessment of the Royal College of General Practitioners (RCGP, 1990), or financial rewards such as a "good practice allowance" (RCGP, 1985a). All of these require a view of what good quality care is, both the minimum acceptable and the best attainable.

The object of the Royal College of General Practitioners is "To encourage, foster and maintain the highest possible standards in general medical practice" (Royal Charter, 1972). Although like all human institutions it has from time to time strayed visibly from that ideal, its members have devoted an enormous amount of energy in the forty years of its existence to the study and promotion of good general practice. The introduction of compulsory vocational training was designed to ensure a threshold level of experience, and hence competence, for entry into the craft. The College examination seeks to assess that this threshold has been achieved (Moore, 1994). The Manchester rating scales set an agenda of excellence against which trainees can be measured (Centre for Primary Care Research, 1988). In more recent years the College has published various suggestions on how levels of work higher than the threshold can be encouraged (e.g. Baker, 1988; RCGP, 1981, 1982, 1990; Haines and Hurwitz, 1992).

Individual doctors too are anxious that their practices should be good, and they have their own views on what that means. Much of our job satisfaction comes from striving to do our job well and many general practitioners have reflected on what they do, from various perspectives.

It seems important but what is it?

Decisions which affect the lives of many people, and the structures and institutions within which we work, all depend on assumptions about the nature of good general practice. Implicit in the views of those discussed above is a belief that we know what constitutes good general practice, even if it is difficult to measure validly and reliably, and even harder to agree on.

What is striking is the lack of open discussion of the fundamental principles on which the various political decisions and standards are based, and of explicit theories of what is good and why. There is much discussion of particularities. Debates about personal lists and the use of deputizing services are interminable, but very little discussion takes place on what holds our views on these things together to give general practice a coherence and unity.

In practice does this matter? Surely it is self-evident what health and illness are, and what general practitioners should be doing. Is it merely an idle academic exercise to seek for an underlying coherence to an essentially practical activity? Can we not all tell a good doctor from a bad one?

Whilst we may all agree in identifying a very bad practice, it is less easy to define a good one. A brusque, unsympathetic doctor who diagnoses incorrectly and treats inappropriately in a dirty and cramped surgery would seem obviously bad, whereas a caring and knowledgeable doctor in a pleasant and light consulting suite would seem better. But which is more important, the diagnostic and therapeutic skill, the caring manner, or the facilities? Is a rude but technically competent doctor better than a caring but inept one? Is a poorly skilled doctor in a luxuriously equipped health centre preferable to a more highly trained doctor in less good surroundings? Can these aspects be separated? Where should we set our minimum standards, and which of these qualities should we be striving hardest to promote?

The problem is no different from other hard choices. Few people dispute that cold-blooded murder is wrong, but abortion, euthanasia and capital punishment are far less clear, because the simple issue of killing is confounded by other factors and conflicts of interests. So it is with general practice. Whilst one would prefer to have all the desirable characteristics and none of the bad ones, in the real world hard choices have to be made. Society has to decide whether to put resources into premises or to spend more on training doctors. Within whatever budget and time are available for training, someone has to decide where the resources are to be directed: into making the doctor a better comforter, a better diagnostician, or a better manager.

If we take the concepts of good general practice and quality of care seriously, we need to consider what the assumptions we make about it are, and whether they are in fact true. Surprisingly these issues have not been comprehensively addressed. There is a debate in North America about the lack of a model or paradigm for family medicine, and in particular for family medicine research (e.g. Hankey, 1987; Urberg, 1989) but these and other contributions to the debate have had little influence on British general practice.

This is first because few people read those journals in the UK; secondly because if they were read they would, to some extent rightly, be seen as reflecting the different cultural milieu and ontological insecurity of general practitioners in the USA; and thirdly they are often almost incomprehensible anyway. It is hoped that the present contribution will avoid all three of these pitfalls.

As the discussion above makes clear, such a definition of good general practice must provide a model of the good not only for the doctor's relationship and dealings with individual patients but also with their families and friends. It must provide a rationale for decisions about the 'shape' of the care offered by a practice to its patients, both in terms of what sort of care is offered for what sort of problem (which areas are emphasized and which ignored); and also the way in which that care is delivered, from the single-handed practitioner at one extreme, to the multidisciplinary 'primary health care team' at the other. It must provide a strategy for resolving the tension between the needs of the doctor's individual patients and the wider needs of society.

As well as guiding the individual or group of practitioners in their day-to-day decisions, such a concept underlies views on what sort of political and social structures would be most suitable to promote good general practice.

CHAPTER 2

What does it mean to ask what is good?

WE HAVE established that various groups of people have views on good general practice and quality of care, and that to answer the question "What is good general practice?" is an essential preliminary to a considered view on a range of issues. We now have to consider the nature of the question in order to determine how we might answer it and who is competent to attempt an answer.

An investigation of the nature of good general practice could be thought of as a purely professional matter, the concern of general practitioners alone, or as an issue where others have something of value to say. It could be seen as purely a clinical matter, defining protocols and policies for good practice; it could be a work of sociology, describing the attitudes of doctors or others working in general practice or in other areas; it could be a work of history, describing ideas about the nature and purpose of general practice, and how these have been shaped by social forces and intellectual movements; or it could be a moral question, concerned with the nature of the good (a traditional moral issue) and its relation to general practice.

A question of belief?

Each of these approaches would contribute in different ways to our understanding of what general practice is about. The first thing about which we must be clear is the difference between "What do people believe good general practice is?" and "What is good general practice?" The first is a question for medical sociology, medical anthropology, or medical or social history if phrased in the past tense. It is a question *about* medicine rather than a question *in* medicine. Proper ways to answer it include social survey (sociology); analysis of historical documents or by historical interview (written or oral history); or participant observation (anthropology). All these are worthwhile and valid activities, but they do not provide an answer to the question "What is good general practice?"

Because something is widely or even universally believed, it is not necessarily correct. Despite the rhetoric of advertisers, ten million people can and often have been wrong. Whole societies have accepted practices such as slavery, torture and genocide, which we would condemn. How can we be certain that our society is not similarly in error? Whilst this is not the place to discuss the epistemology of values in detail, these examples demonstrate that what is right is not necessarily discoverable by public opinion poll.

A technical problem?

Is it then a matter of technical judgement, to be settled by the medical profession amongst its own members, using established scientific research methods? Is an enquiry into the nature of good general practice a large-scale review of the research literature? Many authors have written as if this were the case. The Royal College of General Practitioners, for example, in pursuit of its objective of "fostering ... the highest possible standards in general medical practice" has produced a series of influential papers on health and prevention in primary care (RCGP, 1981, 1982). These documents argue almost entirely in empirical terms. The authors review epidemiological evidence, data on current service provision, and assess the practicability of various changes and developments in practice which could be implemented and their likely effect. They have been widely influential and discussed as proposals about what good general practitioners should be doing. Indeed many general practitioners who would be widely held to be good have studied these documents carefully and sought to implement them in their own practices.

Fragmented answers?

The best general practice is, in this view, that which displays the highest competence in achieving the desired ends (including organization and attitudinal features, as well as clinical skill) and defining good general practice consists merely in establishing what the best means are.

Whilst such work is of great importance, this approach suffers from the problem of fragmentation. General practice is seen as an amalgam of specialties, a transverse slice, as it were, across the cake of medical practice (Figure 1). Good general practice is the sum of good cardiology, good paediatrics, good diabetology, and so on. Perhaps this tendency to fragmentation comes from medical training in hospitals which is organized on the basis of specialties. Also it is simpler to set standards over a small area than to address more global issues. In a limited area quality issues are technical and easier to address.

Scientific methods are excellent for answering well-defined empirical questions about a precise area. Attempts to set standards and define good practice and high quality care have tended to adopt this piecemeal approach, tackling individual services or diseases. Quality of care has been well defined for several such small areas. Protocols or 'guidelines' produced for a wide variety of chronic conditions and health promotion activities are examples of such definitions of quality of care for small areas of care, for example hypertension, asthma, diabetes and cervical screening (Haines and Hurwitz, 1992).

However, work of this type no matter how excellent cannot provide a global vision or set priorities. It cannot give us an overall policy or goal. Rather it addresses the quality of

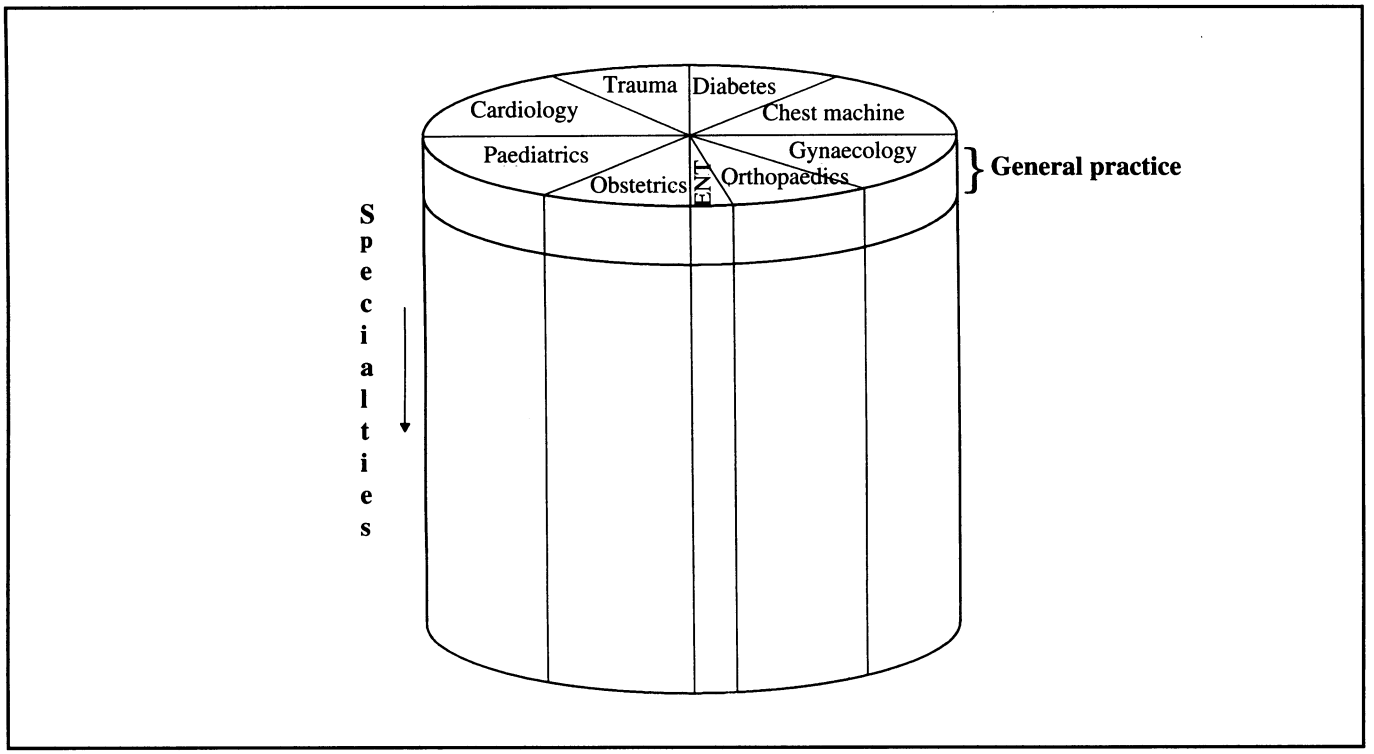

Figure 1 The "cake" of medical practice.

what is already defined as the proper concern of general practice *in the way in which it is already perceived* (or in one of the ways in which it is perceived when there is conflict). When that perception is confused then it can do nothing to resolve that confusion. Thus this approach cannot provide a total answer. The definition of good diabetic care and good asthma care separately cannot help us to decide which should have the higher priority. This question has to be posed at a different, more fundamental level. We need an overall vision of our enterprise if we are to be able to set priorities in service delivery and training, and to make choices between different courses of action in clinical situations. The same is true if we are to decide rationally between different political structures under which general practice might operate, and to reward 'good practice' either financially through the way general practitioners are paid, or by honours and marks of distinction such as Fellowship of the Royal College of General Practitioners (FRCGP).

The pragmatic approach, beloved of the British, in this case carries the danger that the use of isolated 'performance indicators' tends to emphasize what is easily measured rather than what is most important. This can, for example, be seen in the health promotion banding system, where the indices of success are the easily measured recording of data about patients rather than influence on health-related behaviour, which is not necessarily correlated with recording rates. This is hard to measure but is ultimately what matters. The piecemeal approach can distort priorities and leave important areas where assessing performance is hard (as in the first clinical case in Chapter 1) in a 'quality vacuum', without any standards at all. Doctors are left to decide what is best to do on the basis of gut feeling or intuition rather than on considered principles.

The most fundamental difficulty with this approach, however, is that it is based on a false understanding of the nature of the question. The confusion between what is good general practice and what is believed to be good general practice, and the attempt to decide what is good by data collection both arise from what Ryle (1949) and other philosophers refer to as a category mistake, in other words to think that something belongs to one class when in fact it belongs to another. They are examples of category mistake which will be the constant concern of this and subsequent chapters; the confusion between a factual statement and an evaluative, between an 'is' and an 'ought'. Since the confusion between these two aspects of medical judgement, and the difficult task of avoiding it, is central to what follows, we must examine it in some detail.

Telling an 'is' from an 'ought'

Perhaps the most famous comment on the problem is that of the Scottish philosopher Hume (1740):

> I cannot forbear adding to these reasonings an observation which may perhaps be found of some importance. In every system of morality, which I have hitherto met with, I have always remark'd, that the author ... makes observations concerning human affairs; when of a sudden I am surpriz'd to find, that instead of the usual copulations of propositions, is and is not, I meet with no proposition that is not connected with an ought or an ought not. This change is imperceptible; but is, however of the last consequence.

Elsewhere Hume (1740) makes his point more succinctly: "The distinction of vice and virtue is not founded merely on the relation of objects" (Book 3, section 1).

Hume was speaking of moral philosophers; but he could have made the same criticism of almost any medical writer. The "observations concerning human affairs" which doctors make as clinicians are intimately bound up with judgements

of value, of what ought to be. In order to think clearly about what good general practice is, it is necessary to disentangle these two types of judgement, which I shall refer to hereafter as empirical and evaluative.

An empirical judgement concerns a matter of fact which is at least in principle open to falsification by the production of evidence. A clinician who believes that a bone is broken will obtain a radiograph in an attempt to support that view. If the radiograph does not support that opinion, then either its evidence is accepted or rejected, or further evidence is sought (for example, another radiograph after a period of time, when small fractures become clearer).

Sometimes it may not actually be practical to test an empirical judgement. Nevertheless if such evidence could in principle be obtained, the judgement is empirical, even if it is decided to proceed without any rigorous testing. All of clinical medicine, and general practice in particular, is full of uncertainty and decisions taken on grounds of probability not certainty.

In contrast an evaluative judgement is one about the desirability of certain outcomes over others. The *Oxford English Dictionary* (1989) defines values as "the principles or standards of a person or society, the personal or societal judgement of what is valuable and important in life". Both these aspects of the concept apply. The value judgements we are concerned with are decisions about the relative value, and therefore desirability, of various outcomes.

Although one can argue about what makes an outcome desirable (the nature of the good, in philosophical literature), the final decision is taken not on a balance of the evidence but on the basis of a preference for one state over another. I cannot produce evidence to show that life without a broken arm is 'better' than life with one without a prior view of what constitutes a good life. Empirical studies might demonstrate how the two states differ, and I might be able to refine by logical reasoning what it is about not having a broken arm that I value, which would give clarification of what I mean by 'better'. However, as Hume pointed out, collecting more data would not decide the issue.

Distinguishing means from ends

Another way of looking at the distinction is as between means and ends. Statements about means link two states by a course of action: "If you are A and you want to be B then you ought to K." For example, in general practice: "If a patient has congestive cardiac failure and you wish to decrease the shortness of breath then you should prescribe a loop diuretic"; or "If you have a significant number of diabetic patients and you wish to help them avoid the long-term complications of diabetes then you should set up a mini-clinic."

This type of statement is empirical, being at least in principle capable of being tested by collecting data. K-ing is valued not for itself, but as a means to an end; in this case B. It is this sort of statement that forms the basis of clinical science. 'Good practice' in this sense links the initial and desired states by a cost-effective course of action.

In contrast an end is valued in itself and not as a means to some other end. Decreasing the shortness of breath and avoiding long-term complications of diabetes may be such ends; on the other hand they may be merely means to a further end, such as prolonging life or relieving suffering. In any situation, however, we must eventually reach a goal valued for itself, and not merely as a means to some further end; a B which is of intrinsic value.

The empirical/evaluative distinction in practice

Separating the two elements in clinical practice does not of course commit one to the moral philosophy of Hume. It merely helps to clarify our thinking to distinguish these two elements of medical judgements. For example, in the case of the elderly man in Chapter 1 the doctor is faced with a clinical judgement, whether to admit the patient or not. This judgement incorporates both empirical and evaluative aspects, views about both means and ends. The decision depends in part on empirical matters of skilled medical judgement, such as how likely it is that he has had a heart attack and if he has whether the outcome will be different if the patient is admitted. The doctor needs to know what is likely to happen if he is sent to hospital, to predict how much distress and discomfort will be involved, and how much might be treated adequately at home. If it is felt that finance is relevant, the doctor will need to cost the different possible courses of action — an ambulance, investigations, and inpatient treatment.

Interpersonal judgements are required too; how will the patient respond to the possibility of hospitalization? Will he take it matter-of-factly, or will it make him anxious and distressed? How will it affect his wife? If the doctor is honest she will also admit to internal reactions to the possible courses of action and outcomes. Will she feel guilt if the patient is not admitted and subsequently dies, or embarrassment with hospital colleagues if the patient is sent in and it turns out to be something trivial?

These are hard judgements which cannot be made with any certainty. *Ars longa, vita brevis.* But they are empirical, no different in type from a surveyor's judgement that a house is structurally sound, from a lawyer's judgement that a case is likely to win in court, or the motor mechanic's view that an engine part is worn out. They have the form: If the state is A and I do K then the state B will result.

The final decision includes also an evaluation which depends on the value the doctor places on different outcomes, weighing the benefit of hospital investigation and treatment against the distress and discomfort these might involve. This depends on the value placed on extending life against other factors such as 'quality of life'. Similarly the doctor must decide how much weight to give to the reaction of the family, and in a State-funded service how much to take account of the relative costs to society of the alternatives. Should the personal physician act as a rationer of resources, and if so on what basis? Finally the doctor must decide what if any value to give to personal feelings about her decision. Does it matter whether the doctor is comfortable with the decision made, or is considering this egocentric selfishness?

Similarly in the second case, many people would assume that this is a judgement with no moral content. The issue is how likely, bearing in mind his state of health, the degree of positivity of his BCG, and the epidemiology of the disease in his area, is the young man to have active tubercle. Whilst this is the main element in the judgement, the doctor must

also balance the risks and benefits of advising the chest x-ray. This involves evaluating the small risk and inconvenience of the radiography against the potential benefits. These may include not merely the benefit to the patient himself but the public health benefit of making a diagnosis before the index case has the chance to infect anyone else. The presence of an immunosuppressed father in the home may or may not be relevant here. Whilst both risk and benefit are small they are real.

Why the category mistake is made

Confusion often arises because the evaluative element is uncontroversial and unstated. The values seem so obvious that they are not worth stating. Relieving shortness of breath, avoiding complications of diabetes, and setting broken arms fall into this category. We would think it very strange if someone with a broken arm, when offered treatment, replied: "No thank you, I prefer it like this."

In many cases the uncertainty of the empirical judgement is so great that it overshadows the uncertainty of the evaluative judgement when this is not particularly controversial. Difficulties are more apparent when value choices are less straightforward. For example, a patient may refuse to have a broken arm set for fear of the short-term pain, and the doctor may have to decide what steps if any it is right to take to induce the patient to accept treatment. There are two conflicting values here: what the patient says she or he wants and what the doctor believes to be the best treatment.

Although the value judgements in the sample cases are less obvious, they also involve different 'goods', which cannot be pursued simultaneously, and someone has to decide which to prefer. Is a small chance of a life-saving treatment in hospital worth the discomfort and disruption to family relationships it would entail? Does a small risk of tuberculosis merit the expense of a chest x-ray?

Hidden values elsewhere

This combination of empirical and evaluative statements is practically universal in medicine, not merely in clinical cases but in more general policies and attitudes. For example, consider this statement from the evidence of the Royal College of General Practitioners to a Royal Commission on the National Health Service (1985b):

> A relaxed, continuing relationship between doctor and patient is not only rewarding to both but gives confidence to many people, especially young families and the elderly.

At first sight this is an empirical and uncontentious statement, reminding the reader of the obvious. It can be divided into a series of hypotheses which could be tested by research, probably a social survey, thus:

- Patients are rewarded by a relaxed, continuing relationship with a doctor.
- Doctors are rewarded by a relaxed continuing relationship with a patient.
- Patients have more confidence in doctors with whom they have a relaxed, continuing relationship.
- Elderly people and young families show a greater correlation between confidence and a relaxed, continuing relationship than do other groups of patients.
- Such relaxed continuing doctor-patient relationships are better provided in general practice than by other systems of care.

These hypotheses do not imply the desirability of the outcomes — confidence of the patient in the doctor, the patient being rewarded by the relationship with the doctor, the doctor being rewarded by the relationship with the patient. There are also implied assumptions about desirable outcomes:

- That a rewarding relationship between doctor and patient is a desirable end.
- That patients having confidence in their doctors is a desirable end.

These appear to be statements of the value of an end. It is of course possible that it requires further unpacking. For example, it may be that confidence in the doctor by the patient is not valued in itself but merely as a means to another desired end. For example, if patients have confidence in their doctor then the medicines which the doctor prescribes may relieve symptoms to a greater extent. It is therefore the symptom relief which is desired, and the relationship between state A (confidence in the doctor) and state B (relief of symptoms) is yet another empirical statement. Again ultimately we reach an evaluative judgement, namely that symptom relief is desirable.

Disentangling empirical and evaluative elements

Although it can be clearly established that statements about practice, and disagreements about such statements, usually include these two elements, confusion between them often arises. There are two main reasons for this. First the evaluative element is frequently implied rather than stated, and the ends assumed to be desirable. The last example appears under the heading "Our assets listed". Confidence and rewarding relationships seem desirable, yet closer examination reveals possible objections. The critic might argue that it is no business of a health care system to provide its workers with rewarding relationships. Doctors are well paid for the work they do, and it is not a valid argument in favour of a system that it rewards its workers emotionally.

Secondly, in general we do not consciously separate the two aspects, but consider them together. They are like different strands in a rope, intricately twisted together. But before we can look at either question adequately we have to be clear what sort of question we are asking. Failure to do so can lead us to assume implied values which we would not consciously accept, or to attempt to answer an evaluative question as if it were an empirical one.

Although intertwined in everyday practice, the two aspects can be separated logically. It is rather like a red circle. The quality of circularity and the quality of redness are distinct, and can be discussed separately. But just as when we see a red circle, what we see and think of is 'a red circle', not a red object and a circular object, so when we see a

patient with heart failure we think of her as a patient with heart failure, not a patient who is ill and who has the disease of heart failure.

The elucidation of the issues involved in a complex activity such as general practice may be compared to tidying up an overgrown pergola. The plants have grown together into a luxuriant tangled mass. The first task is to separate the intertwined branches of the different plants of empirical and evaluative judgement, carefully untwisting them, taking care not to damage them in the process. Next one traces the subsidiary branches back to the main stems, and the main stems back to the roots, the basic evaluative and empirical assumptions. Although it is possible to hazard a guess at whether a branch belongs to an empirical or evaluative rootstock from its foliage and flowers, unless it is traced back to its root with logical rigour one may fall into error. There may be two very similar clematises in the pergola.

Having distinguished the two elements we can choose appropriate methods of answering our questions. If, however, we fail to distinguish the two aspects of colour and shape in our red circle, then we may find ourselves trying to use geometry in order to distinguish red from blue — not a fruitful exercise.

Disentangling illness from disease

The most rigorous 'disentangling' work in medicine has involved the concepts of illness and of disease. Fulford (1989) starting from the area most commonly seen as posing problems, the nature of mental illness, has analysed the issue with great care, demonstrating that the terms 'illness' and 'disease', although incorporating factual elements, are essentially and primarily evaluative. This is as true of physical illness as of mental illness, and the evaluative element is more predominant in the concept of illness than of disease (Toon, 1981).

The disjunction between the concepts of illness and disease becomes apparent in those classifications made in medical terms which do not carry a negative evaluation. There are a number of nosological or 'disease' categories which are not illnesses — for example anatomical variants or benign biochemical anomalies such as Gilbert's syndrome (Figure 2).

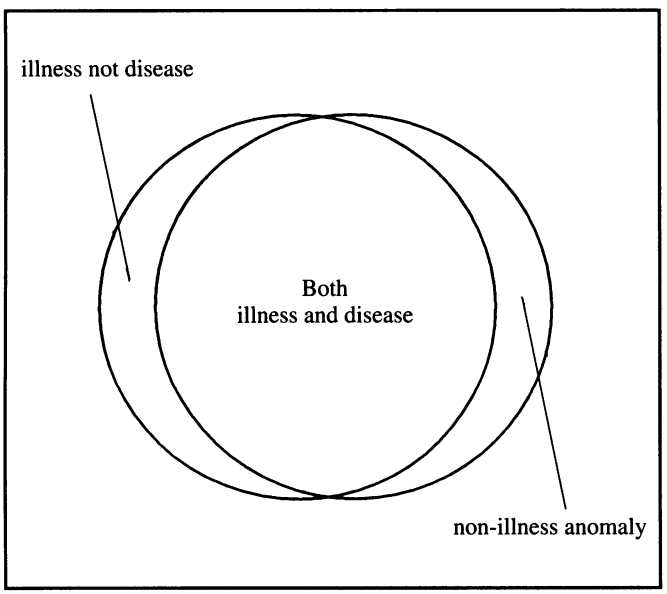

Figure 2 The relationship between illness and disease.

Disentangling other judgements in medicine

The same argument applies to other medical concepts. Empirical and evaluative elements can be found, in different proportions, in all judgements in medicine. A therapeutic or investigative decision (like the two cases discussed in the first chapter), a decision about style of practice, or a managerial decision about practice policies or practice organization, similarly incorporate intertwined evaluative and empirical judgements.

Take, for example, a recent paper entitled "Should general practitioners use their patients' first names?" (McKinstry, 1990). The title, particularly the use of the evaluative 'should' implies an evaluative element to the debate. His choice of method, however, is entirely empirical. The content of the paper is a patient survey of patients' preferences as to whether they are called by their first names. The paper would be more correctly titled: "Do patients like to be called by their first names?" This is an important step, but not the only one, in the argument that patients should be called by their first names. The argument can be unpacked thus:

- Doctors should do what pleases their patients (evaluative statement).
- Patients like to be called by their first names (empirical statement).
- Therefore, doctors should call their patients by their first names.

As is so often the case, the author feels that by collecting data on the empirical issue, the evaluative question has also been dealt with. It may appear uncontroversial that doctors should please their patients. However, there are obvious examples when they do not seek to do so. For example, the giving of bad news rarely pleases a patient, yet many doctors feel that it is not right to conceal such news. More commonly, patients attend with sore throats and colds in the belief that an antibiotic will benefit them. If pleasing the patient were the overriding goal, then doctors would accede to this request, and doctors who did not do so would be bad doctors. Instead, there is a widespread view that it is the better doctor who refuses to do so (although she or he does so by explaining to the patient why it is not desirable — seeking to take the patient with her, not merely confronting him with a blank no, implying that we do give some weight to pleasing the patient). These cases suggest that whilst pleasing the patient is an important goal of general practice it is not the only goal, or even the most important.

If this is so, then the pleasure patients derive from being called by their first name must be balanced against other benefits which might conflict with it. It might, for example, be argued that it is important that patients see their doctors as powerful authority figures in order to facilitate their placebo healing effect and that the doctor using their first name would interfere with this. This argument also includes empirical and evaluative elements:

- If patients see doctors as powerful authority figures it facilitates the doctor's healing role (empirical).
- If doctors use patients' first names they are less likely to be seen as powerful authority figures (empirical).
- It is more important that doctors are powerful healers than that they please patients (evaluative).

Even this set of statements does not fully unpack the argument. For instance the concept of a 'healing role' is itself likely to include both evaluative and empirical elements which will need to be distinguished.

Another argument might be that the use of first names by the doctor perpetuates an inequality and power differential in the relationship which even if patients like it is undesirable. Again whether this first part of the statement is true is an empirical statement which can be tested by data. The undesirability of a power differential between doctor and patient is, however, an evaluative judgement which involves a discussion of paternalism, and the subtle issue of whether it is paternalistic to be non-paternalistic if the patient wishes to be treated paternalistically.

I have discussed this paper at some length, not because either the paper or the issue is of particular importance in itself, but because it illustrates well the composite nature of medical judgements. The same principle applies to other types of judgement about medical practice.

Values in setting priorities for care

Managerial judgements determine not the advice given to an individual patient on a clinical problem, but broader issues about the practice of medicine.

These decisions are important. Considerable resources are committed as a result of them, and the lives of a considerable number of people affected. To take one course of action requires rejecting other alternatives, which means that we have to make hard choices. It is our values which determine those choices, as much as our empirical knowledge of medical science. If we do not have any coherent principles on which to make these decisions, then they will be made on irrelevant grounds, and we may be led to consequences which we would not have wished for.

For example, decisions about priorities frequently have to be made. If time is limited, should it be devoted to psychotherapy or to screening; to diabetic care or to asthma?

A practice may be considering whether it should set up a diabetic mini-clinic. The partners will have to make empirical predictions of the likely consequences of this action. Will the patients attend? If they do, will it make any difference to their diabetic control? If it does, will this have any effect on their well-being, in the short or long term? Will there be any other consequences of the intervention? For instance, will patients appreciate the interest being shown in their condition, or conversely will all the discussion of complications and long-term risks of diabetes make them worried and unhappy?

Having considered these practical matters it remains to make the value judgements. Are the predicted benefits of this activity greater than the benefits of spending the time and money on other groups? Is it worth making diabetics anxious now to avoid possible complications later?

The empirical and evaluative decisions do not stop when the decision to set up the clinic has been taken. Empirically, will a doctor or a nurse do certain tasks more efficiently? Evaluatively, is it more desirable that patients receive all their care from one person, thus obtaining the rewards which come to clinician and patient from a personal relationship, or would an 'assembly line' approach, which might be cheaper, be just as good? Do patients who understand their illness have lower HbA1c values (empirical)? Even if they do not, do they have the right to be fully informed about it (evaluative)? And so on.

Precisely the same argument applies to the political decisions about the structures under which general practice operates; for example, the long and heated debate which has been conducted about the 1990 revision to the general practitioner contract.

The reader may feel by this stage that the point has been laboured a little. If so, I apologise. However the confusion generated by failing to recognize the distinction is so widespread in medicine that it is hard to make the point forcefully enough.

The philosophical status of the distinction

The distinction between empirical and evaluative questions, and whether it is logically valid, has been debated in philosophy at least since Hume proposed it (Foot, 1967; Hannaford, 1972). It is not appropriate in this context to examine this issue, which is a complex if important part of meta-ethics. There are, however, a couple of points of a philosophical nature which it is important to emphasize.

First the concept of an empirical question as here conceived does not necessarily presume an objective reality in the positivist sense. It is quite possible to believe that reality is constructed, not discovered, and that there are alternative constructions which are possible. This does not prevent the issue being an empirical one in my sense.

Let me give an example. It was once believed that cholera was caused by noxious miasmas, gaseous substances given off by dirt, the sick and the dead, and so on. Thus one avoided such contagion by carrying a posy of sweet-scented flowers. Then John Snow formed the hypothesis that cholera was transmitted by water, and turned off the Broad Street pump. Later doctors believed that cholera was caused by *Vibrio cholerae* and tried to eradicate it and to kill it with antibiotics when people suffered from the disease. Most recently cholera has been treated largely by rehydration with large volumes of isotonically balanced oral fluids. Although these views and the data which determine them are not value free, in the sense of being based on atheoretical observations, they are not evaluative in the sense described above, that is they do not within themselves point to a preferred state of affairs.

Neither does the use of the distinction in the present argument depend on the meta-ethical validity of the is/ought distinction. For our purposes it does not matter whether ultimately an ought can be derived from an is. The distinction has withstood sufficient argument to show that they are at the very least quantitatively if not qualitatively different. In applied ethical discussions maintaining the distinction is a protection against the much worse error of failing to recognize an implicit value system, so prevalent in medicine.

Given that judgements about medical practice are both empirical and evaluative, how should we proceed? The methodology for making empirical judgements is well established: scientific research, and the evaluation of its findings to reach sound conclusions, followed by the clinical skill of applying these findings to the individual case. Although this part of the question is important, it need not concern us further for the time being. Although not always obvious, it is possible to distinguish those elements of judgements which are technical skills from those which involve moral values. Having untangled the twisted stems of empirical and evaluative judgement, we then need to trace the stems of evaluation back to their roots.

Not only has the evaluative question been much less extensively considered, it is the more fundamental one. Until the evaluative question is addressed, there is little purpose in considering the empirical. There is no point in asking the way until you know where you want to go. The next chapter will therefore consider how we might set about this.

CHAPTER 3

How to answer the question?

Various unsatisfactory approaches

WE HAVE seen that the question is important, and that it contains two elements: an empirical set of questions about means and an evaluative question about ends. The former has received a great deal of attention. Research has been conducted, papers written, conferences held and authoritative statements made on how best to achieve goals such as prevention of heart disease, effective treatment of asthma, or the right treatment of otitis media. These questions are difficult, and there has not always been consensus, but they have been addressed.

One might have expected that the evaluative question would have been similarly discussed. An account of good general practice should be a matter of reviewing an established literature and applying general principles to our situation. Strangely this is not so. Discussions of quality of care in medicine rarely get to grips with fundamental issues of values. The search for a definition of good general practice goes back at least to Taylor (1954) and the foundation of the College of General Practitioners in 1952 (Pereira Gray, 1992), with its aim "to encourage, foster and maintain the highest possible standards in general medical practice" (Royal Charter, 1972). The approaches, however, have changed little, and their limitations have not really been overcome.

Some writers ignore or gloss over evaluative issues, passing quickly from vague generalities to the comforting concreteness of practicalities. Sometimes they assert ends by bald *ex cathedra* statements, seen as self-evident axioms unsupported by argument. Sometimes they appear to misunderstand the nature of the question, attempting to answer evaluative questions by the collection of empirical data. In other cases quality is discussed only in relation to specific problems in practice and not to practice as a whole. This leads to a fragmentary and incoherent approach. Consideration of some contributions to the discussion of quality will illustrate these unsatisfactory approaches.

Some individual contributions

Taylor (1954) sought to answer the question by a survey of practices. His views are practical and detailed, but he sees them as the self-evident conclusions of a wise man which it is not necessary to justify. Whilst his detailed description of the state of the craft at that time still makes fascinating reading, we must question his opinion that "Experience in visiting GPs has enabled one to arrive in a short time at a subjective judgement of quality, and this judgement has been searchingly refined by expert criticism in every case" (p.12).

Not only is his view of good practice subjective; his views seem arbitrary and unsupported by argument. This work therefore contains within it all the characteristics of later efforts to define good practice — the attempt to use empirical data to solve the problem, the fragmented approach and the *ex cathedra* statement (although the use of this term in this context is perhaps unfair to pontiffs, who usually do support their pronouncements of doctrine with clearly stated theological arguments).

A more recent document in the same tradition, presenting a detailed and practical list of characteristics of good practice, although without the detailed survey of practices, has been produced by Martin et al. (1985). Their attempt to move us *Towards Better Practice* is little more than a series of opinions which however sensible they may be are not supported by argument, nor are they based on any unifying principle.

Irvine (1990) illustrates the quick skate over values before moving rapidly onto practicalities. After only four pages on concepts of quality he moves to the comforting concreteness of structure, process and outcome. The remaining 79 pages of his work concern methods of setting standards and monitoring quality of performance, without any indication of what those standards should be. The result is pure form, almost totally devoid of content.

He does, however, give one important reason why this is in his discussion of overall purpose and aims: "... securing agreement, based on a full understanding by all who work in a practice, may well generate considerable discussion and reveal unexpected diversity" (p.43). Whilst the intellectual and interpersonal difficulties that a discussion of underlying purpose might generate may be difficult to deal with, this hardly justifies ignoring them.

His four brief pages on concepts of quality (pp 7-10) do however have the merit of including a summary of one of the most influential views of quality in health care. Donabedian (1980) directs his attention at quality of health care in general, not merely general practice. He does at least begin his work with an extended conceptual exploration of quality. Unfortunately the way he moves from his starting point — that the central definition of quality must begin with "the simplest module of care: the management by a physician, or any other primary practitioner, of a clearly definable episode of illness in a given patient" — leads him to a fragmented approach.

A further problem is his division of management into two domains, technical and interpersonal, which he approximates to the concepts of science and art. He seems to recognize that this division does not quite work, but in making it he does seem to be reaching towards but not quite grasping the distinction between the empirical and the evaluative meanings of the term 'good' discussed in the last chapter.

Despite delineating some important elements in the issue, particularly the importance of considering benefits, risks and costs, his failure to articulate a clear basis for his concept of quality, despite a valiant struggle to do so, forces him in the end back to an expression of opinion. He is clearly not quite happy about this conclusion. He recognizes that evaluation of quality must be based on the balance of health benefits and harms. However, since he does not consider precisely what he means by the terms health, benefits or harms, his definition inevitably remains imprecise, which prevents him from taking the discussion any further.

Unlike many authors who do not see the problem, Donabedian is clearly aware that this is unsatisfactory. One can sense in his writing the sigh of relief when the chapter closes and he is able to move on to his admirably clear discussion of empirical studies and structure, process and outcome.

The Royal College's struggle with quality

If individual writers have had difficulty getting to grips with the fundamental meaning of good practice, then it is hardly surprising that the Royal College of General Practitioners, with the additional problem of achieving consensus amongst a collegiate body, has fared no better.

Perhaps the most influential statement of the nature and purpose of general practice is the job definition in *The Future General Practitioner* (RCGP, 1972). This has been widely quoted and has had a major influence on general practice training and thus on general practice as a whole, but its values are hidden deep inside it. It is a description of what the general practitioner does, rather than what he or she should do; it is descriptive not prescriptive, sidestepping neatly any debate about goals.

The Quality Initiative, which occupied the attention of the Royal College in the mid and late 1980s, includes examples both of skating over the meaning of quality and fragmented empirical approaches. The document launching the scheme states boldly that there is a spectrum in quality of care from "comprehensive care of high quality ... [to] care of such poor quality that patients often seek primary care ... [in other ways]" (RCGP, 1985a). Rather than moving on to analyse in more detail what the differences were between these two extremes, the document hastens to "urgent action" in the promotion of "quality assessment" — although how quality could be assessed if it had not been defined is not clear.

The most practical achievement of the Quality Initiative was the encouragement of simple empirical audits and standard setting in tightly defined clinical or organizational issues. The small disparate projects in the *Quality in Practice Bulletin* supplement to the *Journal of the Royal College of General Practitioners* illustrate this well. However, the way in which the loose bulletins, with no filing system, fell out of the journal symbolized the fragmentary approach of the project. It was apparently not felt necessary to have any overall aim or priorities to give the enterprise coherence.

Whilst one may agree with Socrates that critical examination of one's activity is a good thing (Popkin and Stroll, 1956), this is hardly a sufficient criterion of good practice. Indeed it may not even be a necessary criterion; some would argue that it is possible to be intuitively and unconsciously excellent without ever conducting an audit. The place of conscious self-assessment in excellence is another factor which needs to be considered.

The "What Sort of Doctor?" project (RCGP, 1985c), provides yet another example of the *ex cathedra* approach. In contrast to the prevention reports with their emphasis on data and empirical evidence, this adduces no data but merely states the criteria for the good general practitioner baldly after a brief preamble.

The College's most ambitious attempt to delineate good practice is the scheme for Fellowship by Assessment (RCGP, 1990). In opting for a 'uniform standard' across all practices, the scheme presupposes that there is such a thing as good general practice, unaffected by the variation in the situation and patient population of different practices. What is startling, however, is that whilst the process by which the scheme was set up is described in great detail, the basis on which the criteria were selected from the infinite number of possible ones is not clear.

Inspection of the criteria suggests that it is a mixture of what is comparatively easily measured. Excellence is achieved by the accumulation of merit in various clearly defined areas, based on what is seen as self-evidently desirable and not requiring much further consideration. The justification for the criteria established — why they were considered aspects of good rather than bad practice, and why those chosen were selected as being the most important — is dealt with merely by providing a reference list.

This has the objective of relating the criteria to research evidence and College policy, but there are a large number of gaps in both columns. Since, as mentioned already, the College has not previously reached a coherent, unified and articulated concept of what good general practice is, the link to College policy provides no articulated basis for the selection. The references and sources appear to justify the various criteria on a disparate variety of grounds, including patient satisfaction, empirical outcome and previously defined College policy, with no indication of how these things fit together. The quotation of a limited number of references on each topic without any scholarly review and analysis of the evidence and arguments reminds one of Lang's criticism (1960) of the use of statistics "as a drunken man uses lamp-posts; for support rather than illumination". Both the columns on which the criteria for Fellowship by Assessment are based seem on close inspection to be built on sand.

Problems with moral relativism

Why is it that so many different discussions of quality, to which many educated, wise and informed people have contributed, have had such difficulty in getting to grips with the fundamental nature of good practice? Two possible psychological explanations suggest themselves. One is that the underlying foundations of our values are so well hidden that we cannot see them (it is after all hard to see the ground under your feet); the other is that they are so fundamental that to examine them threatens to bring the whole edifice tumbling down — a risk that we cannot face.

Another more intellectual reason is the mistaken but widespread view that once one has established that an issue is a moral issue there is nothing more to be said. Many people, including some doctors, believe that a moral issue is "mere-

ly a matter of sound judgement based on clinical experience" (Campbell, 1989); the majority consensus of all right-thinking people (a view once expressed to me by a distinguished professor of medicine); or a matter of personal taste. *De gustibus non est disputandum,* so why bother to talk about it?

The first reason is because, as demonstrated in the last chapter, judgements in medicine pack up empirical and evaluative elements together. Therefore it is worth spending time dissecting the two elements of these portmanteau judgements merely to avoid confusing the two types of judgement and trying to solve evaluative problems by empirical means.

A particular danger of mistaking evaluative for empirical judgement is that it can and has led both individual doctors and the profession as a whole to pretend to a right to make decisions where in fact they have no particular expertise. This has rightly been criticized. Empirical judgements are ones where specialist medical training and knowledge mean that doctors are better qualified to make such judgements than lay people. This is not true of evaluative judgements. Whether there is any particular group which does have any particular expertise in making such judgements is itself an evaluative judgement which is open to dispute. Plato thought that there was and proposed that society should be ruled by philosopher kings. Others such as Huxley (1950) in *Brave New World* have expressed their horror at such an arrangement. In either case the medical profession is certainly not such a group. This is not to say that doctors can leave evaluative decisions either to patients or to society at large. Indeed because of the intimate interrelation of empirical and evaluative decisions doctors cannot avoid them; but confusion between the two areas may lead them to make false claims of expertise and authority, and to make moral judgements on the grounds of their professional training, when in fact they are making them as ordinary human beings, no better or worse qualified in this respect than their patients.

One function of philosophical analysis is to avoid making mistakes such as these. It is just as important to avoid this as it is to avoid making empirical judgements on prognosis or diagnosis which are not justified by clinical data or by medical research evidence.

Thus it is worth analysing medical judgements if only to be clear about the nature of the judgement being made. Philosophical analysis can clarify matters considerably. Inconsistencies between different parts of the value system can be discovered and resolved, and the relationship between superficial and more fundamental values can be clarified. This means that evaluative decisions are taken more clearly and reflect the fundamental values of the person taking them. This would be true even if it were accepted that evaluative judgements are 'just a matter of taste' in contrast to the objectivity of scientific empirical judgements.

In fact the difference between the assessment of arguments in science and arguments in philosophy is not as great as one might suppose. Whilst science is concerned with the collection of data, the more important part of a scientific argument is assessing the meaning of those data and what can reasonably be inferred from them. The process of scholarly and clear thinking about issues is not enormously different in scientific disciplines and the humanities, despite the problem of communication noted by Snow (1959) as the division of society into "two cultures". The mere accumulation of figures (accumulative fragmentism, as Kelly (1955) called it) does not add to scientific knowledge, which relies on the development of sound theories to organize and make sense of those figures.

Furthermore, there is a strong case to be made against the relativism which holds that moral judgements are matters of taste. Midgley (1991) has demonstrated that it is not possible to avoid adopting a moral position which one holds to be of universal relevance, and that those who claim to do so are misleading themselves. Doyal and Gogh (1991) have argued cogently that it is possible to produce universal statements about human needs on the basis of our common humanity. If they are correct then a similar argument applies to other fundamental concepts in moral philosophy. This is not, however, the place for a detailed discussion of these meta-ethical issues, although they are of vital importance to the way in which we live and practise medicine.

Can medical ethics help?

If the medical literature, oriented towards solving empirical, means-related questions on a scientific model, fails to address evaluative questions about ends, one might perhaps expect that medical ethics would offer more help. Unfortunately this is not so.

Medical codes and declarations, from the Hippocratic Oath to more modern successors such as the Declaration of Geneva, offer no positive guidance. They are precise about what is forbidden, but define what is good in vague and general terms. Thus the Hippocratic Oath states: "I will not give to a woman an abortive remedy" but "I will come [on medical visits] for the benefit of the sick." The modern Declaration of Geneva is similarly precise about prohibitions such as: "Any self-advertisement except such as is expressly authorized by the national code of medical ethics is forbidden".but vague about prescriptions: "The health of my patient will be my first consideration" (BMA, 1980). Since the primary objective of both declarations is to protect the public from harm and the profession from scandal and disgrace (not necessarily in that order) this is perhaps not altogether surprising.

One might perhaps expect the Declaration of Alma-Ata (WHO and UNICEF, 1978), the international credo of primary care, to be more useful. However it too consists mostly of vague generalities, and its values are concealed in undefined terms such as health.

Nor do the sociopolitical critics of medicine (Illich, 1975; Kennedy, 1981; Seedhouse, 1991) offer much help. They have important points to make which we will consider later. They are however more powerful in analysis and in suggesting what is wrong with medical practice than in proposing constructive alternatives.

In the general study of moral philosophy, there is an enormous amount of work on abstract issues of meta-ethics. This work addresses not questions of the nature "What ought we to do?" but rather "What does it mean to ask what we ought to do?" Then there is a more practical body of work addressing the question "What ought we to do?" but in general rather than specific terms.

Both these levels of analysis are important, and our discussion will draw upon them, but there has not been developed from them a theory to guide us in a sphere of human

activity such as general practice. Most of the applied ethics in medicine has focused on specifics rather than general issues, and on the dramatic and difficult rather than the mundane. Just as for the clinician small questions are more tractable than broader ones, so for the medical ethicist it is easier to analyse an individual case or clinical situation than to attempt an overarching ethical analysis. In both cases the practical constraints of the scientific paper or journal article collude with the daunting magnitude of the broader task to encourage a fragmentary approach.

The moral issues of general practice have in any case received little attention in comparison with the more 'spectacular' problems raised by high technology medicine. Medical ethicists are no more immune to the attractions of the extraordinary or the sensational than the general public or the tabloid press.

North American contributions

There have nevertheless been attempts to work in this area between general moral philosophy and specific issues, to provide a global view of the values underlying good medical practice. Pellegrino amd Thomasma (1981) share my belief that "the crisis of modern medicine lies in the lack of a suitable philosophy of practice whereby nonmeasurable clinical factors and values can be treated with the same attention as clinical indicators of disease."

They develop a well-argued model. The difficulty with using their work to answer our question is that their concept of medicine is very different from British general practice. It is broader in that it covers those areas of medical practice not usually offered by general medical practitioners but provided by hospital specialties in the UK. It is, however, narrower in its exclusive focus on the individual clinical encounter, ignoring the issues of organization and anticipatory care which crucially face general practice today.

Both these features, which it would be unfair to call weaknesses, reflect the cultural and political milieu in which they work. The 'free market' in health care in the USA makes radically different assumptions from even a market-oriented National Health Service, and the relationship between primary and secondary care is totally different in the UK.

The only comprehensive attempt to map good family practice was made by Christie and Hoffmaster (1986). However, since it is the work of two Canadian family practitioners, this too is rooted in the North American experience and is seriously limited from our point of view because of the cross-cultural differences. Moreover, although its subject matter is closer to ours, since it refers to family practice rather than medicine in general, its approach is fragmented and didactic. Eschewing an abstract approach based on moral theory, the authors go too far in the opposite direction and merely analyse a selection of cases in a way which lacks coherence. Furthermore their approach is apologetic, propounding and defending their own moral view rather than considering and evaluating alternatives.

The peculiarity of the British experience

Studying these two North American analyses does, however, remind us that there are a number of ways in which our situation in Britain is unique. The principle of a National Health Service "free to all at the point of delivery" separates the United Kingdom both from those few countries where all medicine is private and the patient pays directly from the much larger number where a third party — a private or State-run insurance scheme — picks up the bill according to preset rules. Although the internal market may lead to changes in the NHS, politicians of all parties have emphasized their commitment to that principle. The aspirations and expectations of both the medical profession and the public have evolved with that as an assumption, unchallenged from shortly after its introduction until recent years.

On the other hand the reluctance of British general practitioners to become salaried (Forsyth, 1966) and the consequent 'independent contractor status' — a hybrid of a salaried and fee-earning professional status which developed from this — makes it different from both the State-run systems of primary care of the communist world and the financial climate of an independent liberal profession, whether underwritten by an insurance system or not.

The 'list' system, whereby patients register semi-permanently with a general practitioner, to some extent antedated the National Health Service. It appears to have had its origins in the 'sick clubs' of the nineteenth century, which originally provided sickness insurance benefit as friendly societies, and gradually extended their benefits to medical care. State-funded cover of this type was provided for all working men under the Lloyd-George Act of 1911, and the National Health Service Act of 1946 in effect extended it to the entire population. It promoted a continuity of relationship between doctor and patient, often lasting many years, and gave the doctor a sense of continuing responsibility between episodes of illness whilst preserving the patient's freedom of choice of doctor.

The vagueness of the job description, and particularly the tautological definition of 'general medical services', as "those services usually provided by general medical practitioners" gave general practitioners the chance to develop their role in a flexible and often very individualistic way. Although the contract is more strictly defined than when it was introduced in 1990, this background explains much of the present situation. British general practice, like the British constitution, is guided but not confined by precedent.

Our clear distinction between primary and secondary care does not exist in many countries. The etiquette whereby a specialist will only see a patient by referral from a general practitioner, and the associated almost total exclusion of general practitioners from hospital practice, has produced a peculiar relationship between the two branches of medical practice.

The lack of involvement in hospital care by most general practitioners (Honigsbaum, 1979) means that general practice focuses on conditions which can be cared for with comparatively simple equipment, at home or in the surgery. A few acute, major and even life-threatening illnesses can safely be dealt with within these constraints: acute infections such as pneumonia, malaria, cholecystitis and diverticulitis, moderately severe acute asthma, and painful conditions such as renal and biliary colic spring to mind. These, however, form a small part of the workload in comparison with minor illness, which causes morbidity rather than mortality; chronic illness, providing continuing care for conditions such as asthma, diabetes, ischaemic heart disease or arthritis over

many years; and preventive care. Although general practitioners can now obtain diagnostic services through the local hospital and microtechnology is bringing more measurements within the range of the surgery, emphasis is still on clinical skill rather than 'high-tech' activities. Acute severe illness requiring intensive nursing, complex diagnostic techniques and rapid interventions are in general the province of the hospital specialist. The role of the general practitioner is to recognize the problem and to arrange appropriate referral, not to deliver care himself.

The peculiarity of our situation makes it futile to hope to adopt wholesale an analysis from a different culture or branch of medicine. Our history gives rise to problems unique to British general practice, although of course elements of them will occur elsewhere. Concepts developed by authors addressing allied fields will provide useful contributions to this work. Conversely if we can answer the question "What is good general practice?" for British general practice in the 1990s, we may be able to draw on the answer for other cultures, other times, and even other areas of medicine.

The way forward

How therefore should we proceed? The application of moral codes of medical practice provides little help. Nor can we build up a coherent model from the fragmentary analysis of individual cases, as Christie and Hoffmaster (1986) seek to do. Whilst the analysis of cases can provide important insights into our values, it alone cannot provide a coherent picture of how we should behave.

The opposite approach would be to start from a general moral theory and attempt to apply it to general practice. There are two problems with this. First it is frequently hard to see how the very general concepts of moral theory apply to practical situations, and to use such theories to develop a real and practically useful theory, a criticism made by Christie and Hoffmaster (1986). Secondly there is a difficulty in deciding how to start this process. Perhaps because of our fragmented moral culture (MacIntyre, 1985) there is a lack of consensus about moral theory. This is indeed the reason that we have to ask the question in the first place. We cannot rely on a moral theory on which there is no consensus to help us resolve the problems which arise from the lack of such a consensus.

Therefore I propose to explore a methodological *via media* between the case-based inductive approach of Christie and Hoffmaster and a deductive method arguing from ethical first principles. This approach will be inductive, seeking to analyse the visions and assumptions of those who have shaped the culture of general practice and to extract their value systems, usually implicit, from their writing.

Although, apart from Pellegrino and Thomasma, there is no coherent attempt to produce a unified moral theory of medical practice, we can study the major influences within general practice in recent decades where one might expect to find an implicit vision. I shall propose that the values of general practice can best be understood by defining three models arising from the background of Western medicine in the biological sciences, the Balint movement, and the development in recent years of the 'anticipatory care' movement. There are other social and political forces within and beyond British general practice which influence our views. I shall consider the implications of two other concepts of good general practice, the consumerist-business model and family practice as promoted in the United States.

I shall briefly define these models and discuss their origins before attempting to analyse them philosophically in order to dissect the moral values and epistemological and metaphysical assumptions implicit in them. The limitations and their relationship to other important movements of thought and general moral theories will be explored.

For each of them there are a number of questions which will need to be considered. First, in line with the principles outlined previously, it will be essential to distinguish those features of the model which make empirical claims about what is good, in other words those that are effective in achieving certain goals, from those which are evaluative, defining the goals themselves.

Although the discussion at first sight appears to be solely ethical there are assumptions just as important which lie in other areas of philosophy. These include metaphysical views of the mind-body issue, epistemological theories of the nature of illness and disease, and a concept of what the doctor-patient relationship should be and the principles on which it is founded. These issues are complexly interlinked; for example the concept of the goal of medicine will naturally imply a concept of illness or disease and a theory of human need. These will also indicate what the nature of the doctor-patient relationship is. This will in turn depend on the view of the human person taken, ideas about responsibility, which in turn incorporates the concept of the goal of medicine, and an attitude to issues of paternalism and autonomy. Consideration of justice will include views on resource allocation and the relationship between the individual and society.

Thus the analysis cannot be a simple list of attributes of this or that model, though insofar as possible the arguments will be laid out in such a way as to make them comparable.

Each model implies a view of the doctor. Many systems in philosophy and in psychology leave the observer outside the system, or adopt radically different models for observer and observed. This has been criticized as a lack of reflexivity (Bannister and Fransella, 1971). In their view an adequate model should account for the behaviour of the person constructing it, so for us the model of how the doctor should treat the patient should give us some understanding of how the doctor behaves. We will see what understanding if any the various models give of the doctor's behaviour.

The models will not necessarily have as an intrinsic part of them any particular view on some moral or philosophical issue which is important. In this respect none of them is complete. Like languages which lack a word for an article or concept, models tend to borrow from current philosophical assumptions to fill these gaps. Like all such borrowings, however, they will not necessarily be indiscriminate; some sets of values slide more easily into a model than others.

The result of these analyses should be a cognitive 'map' of general practice, in which the relationship of the possible models to their underlying philosophical assumptions, and their practical implications, will be set out and the boundary between the empirical and the evaluative elements in the concepts defined. Furthermore the location of this 'map' in the wider conceptual space of philosophical discourse will be established.

It may appear to the reader, particularly to the general practitioner asking himself "What sort of doctor am I?", that the models are artificially rigid and stereotyped. It should

not be supposed that real doctors can be identified as one sort of doctor or another; they are models, not character studies. Part of the uncertainties of concepts of good general practice arises out of the lack of clarity in most doctors about what their philosophical model is, and the inadequacy of available models.

What I am attempting to do is to clarify the debate about good general practice, not to confine any individual doctor, patient or group to a particular position. Characterization of models is almost inevitably a caricaturization. If well done, like any caricature it distorts, but in doing so reveals something of the underlying truth.

Both doctors and patients slip in and out of different models as suits the occasion, like changing our clothes, for the most part ignoring the inconsistencies and incongruities. This may often produce a humane result when done with charity and goodwill, but it can also lead to confusion and inconsistency. The evaluative aspect of medicine deserves at least as much scholarly attention and research as we give to the empirical.

CHAPTER 4

The biomechanical doctor

BECAUSE it is the dominant 'paradigm' of Western medical practice throughout the world (in the sense of a model which is used to organize understanding and research; Kuhn, 1962) the first model I will analyse is the biomedical. I shall consider the historical origins and social setting of the model and the difficulties of applying it to general practice only briefly, since they have been well discussed elsewhere (e.g. Wulff et al., 1986; Seedhouse, 1991). Attempts to modify the model to fit general practice by dealing with its empirical weaknesses rather than its values will be considered. Analysis of those values will elucidate the metaphysical structure from which they arise. This will lead us to look systematically at the stance which the model implies on crucial issues such as personhood, autonomy, responsibility, justice and the doctor-patient relationship.

The basic paradigm of biomedicine

In the biomedical model the doctor is seen as a biological engineer, healing bodies by the application of a knowledge of biology in the same way as the engineer applies a knowledge of physics to machines. Many people, both adherents of this model and their critics (Wulff et al., 1986), use the analogy of the motor mechanic, who analyses defects in a car by applying knowledge of its structure and function and corrects them in the light of this understanding. Alternative labels have been attached to the same model. Tudor Hart (1988) chooses the term "Oslerian model", Wulff et al. (1986) and Seedhouse (1991) "mechanical model".

The model is described best by its opponents rather than its defenders. Being the model of the medical establishment, its adherents have felt no need to define it overtly. Because of this, as Seedhouse (1991) correctly points out, it has been seen as *the* medical model, and has been extensively criticized by critics of modern medicine such as Illich (1975), Kennedy (1981), and Seedhouse (1991) from outside medicine, and by Pellegrino and Thomasma (1981, 1988) and Wulff et al. (1986) from within. Much of the analysis of this model derives from their work, although it would not be practical to cite every reference separately. Nor is it necessary to accept their critical conclusions in order to learn from their analysis.

The roots of the model lie in the scientific triumphalism of the late Victorian period, when the doctor began to be seen as an applied scientist using the biological sciences. These developed rapidly during that period, with the introduction of the germ theory of disease and the study of morbid anatomy to understand pathogenesis. The term 'proper doctor' is an ironic expression frequently used by general practitioners to describe a doctor using the model, emphasizing that it is not merely a model of illness and disease but also a pattern of how the doctor ought to behave. It defines what a proper (in both senses) doctor does. It has dominated Western medicine for most of this century, and still does so.

Most medical education is based on this model. The student starts by acquiring an extensive and largely uncritical knowledge of biochemistry, physiology, and anatomy (Horrobin, 1978). This is then followed by at least six years' training in hospital, where it is easy to obtain detailed knowledge of the blood chemistry and physiology of patients but very hard to understand their daily lives and social situation, or for them to express their feelings. Indeed in Western hospitals this is increasingly the case, for as costs rise the time which the patient spends in expensive hospital care is minimized, so that patients are in hospital for short periods for specific purposes rather than for the whole of a lengthy illness. The hospital provides, as it were, a 'pit-stop' for quick servicing of the dysfunctioning body.

Since the hospital is also the training place for doctors, students adopt the model around which the hospital is organized with its implicit values as unquestioned assumptions. This leads doctors to see the applied biomedical scientist as the only 'proper' sort of doctor. All Western doctors, whatever their current views, have this model as a background.

Balint (1957) refers to the perpetuation of the student-teacher relationship which often arises when the general practitioner is seeking advice from and making referrals to the hospital consultant. Rather than seeing themselves as practitioners with different but equally valid skills, both specialist and generalist regress into roles where the general practitioner, who has largely been taught by specialists, is seen as still a student when he or she seeks the advice of the more learned specialist. A similar process can determine the general practitioner's behaviour in practice. Since he is trained in this model its use and associated values come naturally. We are socialized into it, and like all powerful socialization, its influence continues even if we no longer accept its values. It acts as a medical 'super-ego' controlling conduct, either being used automatically, or producing feelings of guilt when its rules are ignored. Even when it is rejected as a conscious choice the doctor often feels unconsciously that to behave according to this model is what a 'proper doctor' would do.

In the first half of the twentieth century general practice was seen as a poor relation to hospital specialist practice where in a mood of scientific triumphalism biomedical advances were being made at an impressive rate. Although general practice has improved in public image and self-esteem, there is still sometimes a slight problem of self-confidence. One way of dealing with this is to seek to please the super-ego of early clinical teachers behaving as a 'proper', that is a hospital, scientific doctor would.

The general public too has had its views of illness and the role of medicine shaped by this model, exposed to life and death biomedical drama and the excitement of scientific breakthroughs via the media. Indeed the model is perhaps even more influential outside the medical profession than within it. Whatever the truth of Illich's (1975) assertion that biomedicine has made little overall contribution to life expectancy, the empirical successes of the model in some areas are fascinating and impressive. All doctors will be aware of patients whose lives have been extended by procedures such as the grafting of aortic aneurysms, the successful treatment of breast cancer and leukaemia, and prompt resuscitation after cardiac or respiratory arrest. Countless more have had their lives improved by operations such as hip and cataract replacements, and by drug treatment for conditions such as asthma, peptic ulcers, and thyroid disease. These successes have altered popular expectations of medicine, so that some patients resent it strongly when their doctor admits that "there is no cure for this disease" (Belloc, 1940),[1] and believe that this reflects the inadequacy of their present physician rather than being a fact of life. This can put pressure on the general practitioner to seek a solution within this model even when it cannot provide one.

A borrowed suit for general practice

Since, however, the model did not evolve in general practice, its application there raises some difficulties. It is like a borrowed suit which is a little ill-fitting. The awareness that medicine as taught in medical schools is not adequate for general practice is not new:

> It is a common complaint that the [medical school] curriculum bears insufficient relation to the problems of practice. The difficulty of applying scientific principles in domiciliary medicine, and the realization of how much that is met with in practice appears to fall into no definite disease group, leads to dissatisfaction; it is often stated that instruction in the management of men and women, and in business methods, might replace with advantage some of the academic training. At the medical schools time might well be found, despite the many claims upon it, for imparting to students the lessons of social experience...
>
> (*Lancet*, 1927)

This critique comes from a handbook for those contemplating general practice published by *The Lancet* in 1927. The power of the model is shown later in the same chapter when, having recognized its deficiencies, the writer is nevertheless unable to abandon his allegiance to it: "The silence in educational schedules concerning formal teaching on these lines" (in other words imparting the lessons of social experience) "must not obscure the fact that the curriculum is well planned for its main purpose." Precisely what their view of that purpose is the authors alas do not say.

The pattern of illness seen by general practitioners differs from that found in the hospital (Hopkins, 1985). The patients seen in hospital clinics have been filtered and sorted by general practitioners. Whilst the hospital doctor sees mostly acute illness, or acute episodes of chronic illnesses, and the life-threatening rather than the irritating, the pattern is reversed for general practice. The difference is particularly great between general practice and hospital inpatients, the core of medical students' and junior hospital doctors' education. This leads to impressions of different prior probabilities (McWhinney, 1981) which warp clinical judgement when applied uncritically in general practice.

In hospital, illnesses have already been organized into medical terms both by the referral letter the patient brings and the 'shaping' which anyone's story naturally undergoes with telling and retelling. The structure and importance of the different "medical narratives" has been studied and described in detail by Brody (1990) and Hunter (1991).

In contrast patients use the general practitioner for a range of problems across and beyond the strictly medical, and their problems are often ill-defined and ill-definable. It is a first port of call, and many people have a comparatively low threshold for going. One solution to this is to show patients whose problems do not fit the biomedical model the door; however, this is hard for the general practitioner who has a personal relationship with them, particularly as experience shows that they keep coming back!

The resources available are also different. In hospital it is easy to take an x-ray of everyone with a chest problem; in general practice it is difficult. The use of time differs too. The patient has made a great effort to get to hospital, and expects a definitive answer and a considerable allocation of time. It is hard to organize follow-up at intervals of less than a couple of weeks without admitting the patient. Thus decisions have to be made in large chunks after exhaustive enquiry. In contrast in general practice they can be made provisionally, with the option of the patient popping back for a few minutes to see how things are going in a day or two to revise the analysis.

In a hospital many things which are a personal responsibility in normal life, such as remembering to take tablets and deciding what to eat, are taken over by representatives of the institution. This leads to a passivity in the patient's role which is just not possible in general practice.

Empirical modifications for general practice

These problems are not related to the philosophical structure or values of general practice, and are potentially capable of solution by empirical means. There have been many such attempts to adapt the biomedical model to general practice without altering its underlying assumptions. Thus instead of relying on hospital research done on highly selected populations, general practice can do its own research on more appropriate groups. Hospital medicine has concentrated on life-threatening acute illnesses; in general practice we are concerned with illnesses which cause morbidity rather than death, and the chronic rather than the acute. We therefore need to study these using the same conventional biomedical tools which have served the doctor in hospital so well.

Pickles (1939), Fry (1983) and Hopkins (1985) are impor-

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[1] The Chief Defect of Henry King
Was chewing little bits of String.
At last he swallowed some which tied
Itself in ugly Knots inside.

Physicians of the Utmost Fame
Were called at once; but when they came
They answered, as they took their Fees,
'There is no Cure for this Disease.
Henry will very soon be dead'.

tant exponents of this line of thought. These and other workers, both general practitioners and specialists interested in general practice, have generated a substantial body of research. There are innumerable examples of work of this type, published in scientific journals. The series of papers by Bain (1990) and others on the treatment of otitis media is a good example of the approach by general practitioners, whilst Goldberg and Huxley (1980) show specialists contributing to improving the empirical scientific basis of general practice.

Similarly, adjusting the undergraduate and particularly the postgraduate training of general practitioners to include more experience of chronic and minor illness has been tried, in order to adapt the biomechanical model to the needs of the future general practitioner.

It is ironic that as the critique of the basic philosophy of the biomechanical model has grown on many sides, the ability of general practice to work successfully within it has increased steadily. General practice research and vocational training have helped towards this. Changes in health service organization have given general practitioners direct access to a wide range of investigations and to paramedical services such as physiotherapy and chiropody, giving the doctor more power both diagnostically and therapeutically. Increase in self-care for minor illnesses, a decrease in visiting rates for self-limiting illness, and changes in the rules regarding medical certification have freed the general practitioner from the mountain of what the biomechanic saw as trivial or irrelevant work to devote more time to 'proper' (that is, life-threatening, serious, preferably treatable) disease.

Microtechnology and greater flexibility in staff reimbursements could continue this process further. The future of general practice on this model lies in taking over more of the work of the hospital. Minor surgery, computers, and tabletop laboratory facilities are the improvements to which its proponents would give a high priority. In this way the perceived empirical success of biomedicine in hospital can be transferred by amending its content but not its structure to make a biomechanical general practitioner, without any major change to its basic values.

Values in the biomechanical model

What those values are is not obvious. The average biomedical doctor is a pragmatist, not given to abstract speculation. Campbell (1989) quotes someone who says: "When someone starts to talk about ethics, I reach for my golf-clubs." Whether in this case this is as a distraction from unwanted philosophical speculation or to silence the philosopher is not clear, but such attitudes are common. The doctor sees something she or he does not like and sets about changing it without thought of ultimate good or eternal values.

Nevertheless the model is not value free. It is centred on disease rather than on illness; on biological dysfunction conceived in terms of morbid anatomy and pathophysiology rather than subjective distress. The importance of symptoms lies principally in their role in identifying the pathophysiology. Although of course the reason for doing this is to relieve the symptoms, the diagnosis in pathophysiological terms often becomes an end in itself, and not just a means to an end. The observation of disease becomes a fascination like stamp-collecting or botany, with an analogous obsession with the rare, the esoteric and the perfect specimen. This quotation, from a letter written by a cardiologist about a patient found to have a heart murmur at a routine medical, illustrates this mentality beautifully:

> Dear Dr X
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> Let me apologise for not having written to you sooner about this young man who is a wonderful case of untouched coarctation. ... He has beautiful physical signs, widely dilated retinal arteries, with their classic wide tortuosity, etc. Really I was very happy to have such a patient.

An example of the axiomatic necessity of biomedical diagnosis arose in a discussion of the ill-defined and ill-understood chronic fatigue syndrome or myalgic encephalomyelitis (Murdoch C, personal communication). "First of all we must define the pathophysiology," announced the biomechanical triumphalist in a conversation on the subject. When the pragmatist replied "Why?", the question stunned the biomedical doctor into speechlessness. In fact even committed biomechanics treat syndromes of which they have no pathophysiological understanding effectively on an empirical basis, but so central is diagnosis in the paradigm that this feels vaguely improper.

Those using it frequently make the category mistake discussed in Chapter 2 between empirical judgements of scientific outcome and value judgements. The role of medicine is seen as the correction of biological dysfunction and this is seen as an empirical, value-free matter. Because of the central place of disease categories (Toon, 1981) rather than illness, adherents of the model are forced either to define dysfunction in biological terms, or to ignore the issue altogether, the latter being the more common option.

Without proper analysis of medical judgements, doctors and others may be mistaken about what sort of judgement is being made. It is this sort of confusion, for example, which led Kendell (1975) and Campbell and his colleagues (1979) to make illogical and even foolish (Toon, 1975) statements about the nature of disease. They were seeking to define disease, which as Fulford (1989) has shown, is primarily an evaluative concept, in empirical terms. Campbell and colleagues proposed that an illness was a condition which shortened life or decreased fertility. Kendell purported to show, on the basis of mortality and morbidity data from psychiatric populations, that this definition proved that mental illnesses such as schizophrenia fitted these criteria, and hence were bona fide illnesses. He felt that it was important to justify this definition since at the time there had been much criticism of psychiatry (Laing, 1967) and there was a fashionable if minority view that mental illness was a "myth" (Szaz, 1960). Another controversy at the time was whether homosexuality should be considered a mental illness. Since it fitted Campbell and colleagues' definition (1979), Kendell concluded that it was.

Failing to adopt a proper philosophical method of analysis, Kendell overlooked the fact that logically, by his criteria, taking the contraceptive pill or using an intrauterine coil became iatrogenic illnesses. If schizophrenia and homosexuality were mental illnesses, so too was a vocation to the religious life or the Roman Catholic priesthood, since both decrease fertility. These conclusions, which seem absurd to most people, indicate the importance of clear thinking about medical philosophical issues.

Ignoring the matter has worked surprisingly well and has enabled the model to flourish pretty well unchallenged for several decades. This is possible because in many situations, particularly where the model works best — diseases amenable to surgery, infectious disease, and other acute illnesses where drugs can produce a rapid change — there *is* little controversy over which state is to be preferred. The example of a broken arm has already been mentioned; lobar pneumonia, tuberculosis and diabetic coma are similar. It would be hard to argue that medical intervention was not beneficial for the individual, even if Illich (1975) and others are right in their belief that all this clinical intervention makes little difference to the health of the community.

It is only where the model is less effective, for example in relation to chronic illness or psychological problems, that the evaluative difficulties it raises become more apparent. This is why the debate on the definition of illness has arisen mainly in psychiatry although, as Fulford (1989) points out, it is not centrally a problem of mental illness but the problem of defining illness at all. The importance of chronic illness, psychological distress and ill-defined syndromes makes this an issue for general practice also.

When attention was paid to the boundary between health and illness, originally because it was necessary to firm up such boundaries for computer-assisted diagnostic systems rather than because of epistemological debate over the reality and nature of mental illness, the attempt to define illness in purely biological terms was seen as misguided.

Fulford has shown the logical primacy of illness, conceived as action failure, over disease as a biological category. Not only does defining illness in biological terms pose logical problems, it requires the purpose or goal of life to be defined in biological terms (Wulff et al., 1986). In short, life ought to be about longevity and fertility and little else. This seems a reasonable assumption when working in hospital, where the main problems are people in immediate danger of death. However, as a general principle many people find it unsatisfactory. It follows, for example, that the doctor has an absolute duty to do whatever possible to prolong life. Anything else is failure, and if deliberate is passive euthanasia, which is hard to distinguish logically from active euthanasia (Rachels, 1975). Although not principally a problem for general practitioners we do face it quite often, as the first case in Chapter 1 illustrates. The debate about active and passive euthanasia, and the resource implications of expensive treatments with uncertain or limited results, is an outcome of the difficulties people have with this view of what is good.

Problems with an amoral model

Beyond good biological functioning, the model has no view of the good life. If I take my car to the garage to be repaired, I do not expect advice on where to drive it once the job is done. Biomedicine is similarly agnostic. In a morally pluralist society, with a wide variety of personal values and life goals, this is attractive. However when the uncontroversial 'fix the fault' model breaks down, for instance in terminal illness, psychological illness, and untreatable chronic disease, then it leaves the doctor in a moral vacuum. As Kelly would predict, this frequently produces guilt and hostility, with unfortunate results for the patient. If the goal of medicine is longevity then "death when e'er he call must call too soon" (Gilbert, 1888).[2] The death of a patient must be a failure for the thoroughgoing adherent of the biomedical model. This often influences the way doctors deal with death. Since the model provides no way of facing the patient's death themselves, they assume the patient feels likewise, justifying in terms of beneficence the decision to spare the patient (and themselves) the pain of discussing the outcome of the illness. It is this fear, rather than an autocratic desire to control other people's lives, which is usually behind the reluctance of doctors to talk about a fatal diagnosis.

The high value biomedical doctors put on avoiding death will lead them to devote much time and energy to investigating symptoms which might be serious, since the fear of missing major pathology is a central concern. One would predict a low threshold of referral for sinister symptoms such as rectal bleeding from general practitioners using this model, and high spending on investigations. Conversely they will try to minimize the time spent on minor illnesses and minor psychological distress which present in such great numbers in general practice, since this will not threaten the life of the patient.

This is another consequence of training doctors in a hospital centred on the care of the seriously (but treatably) ill. Predominant values in that environment include a high priority on not missing treatable physical illness, and an optimistic view of the explanatory and therapeutic power of the biomedical model. Conversely psychological and social aspects of illness are minimized, or seen as something to be dealt with when the 'real', that is physical problem, has been dealt with. The term 'overlay', commonly used to describe those aspects of a patient's problems attributable to psychological distress, emphasizes the view of these as an 'extra' to be dealt with as a work of supererogation.

The ghost in the machine

This division between the mental and the physical, with the overwhelming emphasis on the latter, reflects Cartesian mind-body dualism underlying the model. A number of features of the model of philosophical interest flow from this. Many of them reflect the rational, individualist attitudes of the Enlightenment concept in which they have their philosophical roots.

The matter of concern is the 'machine', in other words the body of the patient and its dysfunctions. If the biomedical doctor is a mechanic, then he is the mechanic who mends the machine in which a ghost lives. The mechanic-doctor will talk to the patient as the 'owner' of the machine (to the "ghost in the machine"; Ryle, 1949) but the good biomedical doctor like the good mechanic will not want to waste too much time on social pleasantries but prefer to get his hands dirty quickly. Therefore, although conventionally consultants are referred to as having patients 'under their care', this technical use of the term is not equivalent to

[2]Is life a boon?
If so it must befall
that death, when e'er he call
must call too soon,...
what kind of fate have I
who perish in July?
I might have had to die perchance in June.

empathy with the patient's suffering or conventional expressions of regret. Although regarded as desirable, these activities which accord with everyday notions of care are supererogatory, of far less importance than technical acumen. This often gives rise to conflict with nurses, whose model places a much higher value on a caring relationship with the patient.

This is not to suggest that biomedical doctors are callous, but that caring is seen in a narrow, practical sense. For example, a hospital registrar once told a general practitioner during a shortage of beds that it would not be appropriate to admit a patient, since the reason for admission was "only on compassionate grounds". This revealing statement does not imply that hospitals do not exist for compassionate reasons. Rather the patient required only nursing care and pain relief, which the doctor did not feel justified admission. There was no need for the technological resources which he saw as the justification for hospital admission. This priority given to practical, mechanistic activity characterizes this model. Lack of sensitivity to human suffering is not intrinsic to it, although the model may foster it. The merit of the attitude of impersonal detachment is that it enables the doctor to bring to the patient the power of an objective, scientific analysis of a situation, whilst preventing the human emotions which occur when faced with the awful reality of human suffering from interfering with this process.

The doctor-patient relationship

The doctor-patient relationship in this model is an impersonal one. Since medical practice is a technical skill, it matters little by whom it is exercised, so long as the competence is adequate. Thus it does not matter if patients, as in many hospital outpatient clinics, see the next available doctor, and see a different doctor at each visit, so long as all the doctors are adequately trained.

This same dualist metaphysic accounts for the unreflexive nature of the mechanical model; in other words it cannot be applied in the same terms to the doctor and to the patient. There is an essential asymmetry between the doctor and the patient. The 'ghost' of the doctor surveys the 'machine' of the patient. The doctor is the objective observer outside the system (the patient) which she observes, just as the Newtonian physicist does not take account of the effects of his measurements on his system. The principles which the doctor applies to the problems of the patient are different from those which she may apply to her own problems. The doctor can of course become a patient when the need arises, but only by abandoning her persona and becoming a passive machine herself. Perhaps this in part explains why doctors are notoriously bad at dealing with their own illnesses and living a healthy life.

The individualism of the model

The view of the patient and the doctor-patient relationship is intensely individualistic. The doctor treats many patients, but does so one at a time. Each individual 'biological machine' and each individual doctor-patient relationship is separate from the others. This detached individualism raises difficulties for the general practitioner when several different patients closely related by blood or by choice are cared for by the same doctor. Except for general medical, ethical guidance on confidentiality, the model has no way of dealing with this situation, since it sees individuals primarily in isolation and only secondarily in relationships — another consequence of the Enlightenment inheritance.

With its individualism the model has little to say about justice. This is one of Tudor Hart's most stringent criticisms of it. Since it is intrinsically an expensive model of care, and is becoming unaffordable as technology advances, this type of medicine cannot ever be fully available to all. What we have seen in practice is two alternatives, neither intrinsic to the model but borrowed from other social theories. Either everyone gets an inadequate bit, the socialist solution, or the full service goes to those who can pay according to free market economics.

Detachment of the illness from the patient

An interesting feature of this model is the view of illness and episodes of illness as separate from the body and from life; the episodes are interruptions, the illnesses detachable; often literally in the case of surgical treatment. To return to our motor mechanic analogy, the purpose of the car is to be moving along the road, not on a ramp in the garage. The time spent on the ramp is an interruption of its normal 'life'. The defective piece is removed and replaced, and the driver then carries on as before.

This approximates well to reality in hospitals, where patients are removed from their normal activities of life, their home and their family. A stay in hospital is 'time out' from normal life, and it is easy to see the return home as the taking up of the threads after an interruption as if it had never occurred. Illness is detached from life, and not part of the individual's narrative (MacIntyre, 1985; ch. 16), any more than a double-glazing salesman becomes part of the conversation which he interrupts. It is harder to sustain this division in general practice, where the patient pops in to see the doctor whilst shopping in a setting which is as familiar as the supermarket, or the doctor deals with the patient on his territory, in his living room or bedroom. It is also harder with chronic diseases which patients and their doctors live with over long periods of time, which must of necessity impinge on the patient's life narrative.

A notion of the doctor-patient relationship which characterizes the model follows. The doctor responds to the patient's presenting illness, follows the patient until this illness is over and then hands back to the patient responsibility to return when she or he thinks fit. Just as the hospital doctor will write to a general practitioner at the end of an episode of illness, telling the doctor that the patient has been "discharged to your care", similarly the general practitioner will discharge the patient "to his or her own care" between episodes of illness. Traditionally mechanics do not take machines which their owners believe to be working satisfactorily apart. "If it ain't broke, don't fix it."

Attitudes to autonomy

An attitude to autonomy follows logically from these assumptions. Traditionally autonomy was little considered at all. Doctors were expected to be paternalistic, and a model

which saw the patient's body as a machine and doctors as engineers reinforced the traditional paternalism of the medical profession which some trace back to Hippocrates (Pellegrino and Thomasma, 1988). The patient was supposed to abandon all responsibility to the physician or surgeon, and be as passive as a car on an inspection ramp. Patients still speak of being 'under the doctor' or more alarmingly 'under the hospital'. Although less common than formerly it is not unknown to hear talk of 'doctor's orders'. Doctors speak of 'managing' patients, and patients are referred to anonymously as 'a case of x disease'.

This attitude fits naturally into a mechanistic view. It is hardly likely that a machine can have a view on how it wants to be treated, or indeed feelings of any kind. With externalization comes absolution from responsibility. The patient cannot logically be held responsible for the disease which is an external feature. Disease takes place in the physical universe, where determinism rules and free will is absent. Physical illnesses 'caused' by psychological factors raise serious difficulties for the model. For this reason those using the model often assume either that psychosomatic causation cannot occur, since it breaks the metaphysical barrier between mind and body; or that to suggest a symptom has psychological causes is to deny its reality, since the mental world is less 'real' than the physical. Nor does the model provide any framework for dealing with responsibility for self-inflicted illness, such as overdoses. When faced with this situation, biomedical doctors commonly react with hostility. Kelly (1955) pointed out that this occurs when a core construct cluster — in this case the metaphysic of the model — is under threat.

When people began to be concerned about autonomy the model had little difficulty in dealing with it without any significant change in its structure. The autonomy of the rational Kantian being is a central concept of Enlightenment thinking and this view therefore slots into the model without difficulty. If the body was the machine and the doctor the mechanic, then autonomy lay in the hands of the owner. Doctors must no more interfere with their patients' autonomy than borrow their cars without permission. The externalization of illness promotes patient autonomy in a 'hands off' sense: the patient decides that there is a malfunction (illness) and seeks treatment according to the patient's agenda. Whilst the door may be open, it remains the responsibility of patients to walk through it, and once treatment is over they walk out again and do whatever they will. It takes only a little 'slot rattling' (a change in view which occurs by moving from one point of view to another without changing the structure of the cognitive system; Bannister and Fransella, 1971) to make 'hands off' autonomy fully respected in this model by discussing and seeking consent to every test and intervention suggested to mend the machine. Since disease is externalized there is however little room for self-management and health promotion.

The impact of the doctor's value system should accordingly be limited strictly to the value of good biological functioning. In fact this is not always the case, since few doctors can avoid filling the moral vacuum of the model with their own value structures.

Conclusion

I hope this analysis has demonstrated that although at first sight biomedicine is an empirical model, it also contains major assumptions of values. It incorporates a mind-body metaphysic, a notion of the good, a concept of the nature of autonomy, whether that autonomy was respected or not, and a set of presumptions about the doctor-patient relationship. It has a particular notion of the purpose of medicine, which perhaps is a result of a category mistake, confusing as it does the empirical value of a model promoting good functioning in biological terms with the ultimate value of such functioning. Because of the dominance of this model these assumptions have widely been accepted as the only possible ones in medicine. It is only when looking at alternative models that we begin to see that this is not necessarily so.

CHAPTER 5

Teleological and hermeneutic models

THERE are several strands of thought in medicine which might variously be labelled teleological, hermeneutic or humanist. They conceive of life as having a definite purpose, hence the description of them as teleological. They emphasize the role of the doctor in helping the patient to understand illness and to deal with it as well as or instead of the curative role, and so can be referred to as hermeneutic. They have in common a vision of medicine as quintessentially a humanist activity, which is concerned with human relationships.

An example of such an intellectual movement which has arisen within British general practice, and is thus particularly relevant to our question, is the Balint movement. It also has the merit of being well documented and very clear about its principles. The model implicit in Balint will therefore be considered in some detail. It is, however, possible to practise medicine according to a very similar model without ever having studied Balint or thinking of oneself as a Balintian. Some movements with similar implicit models will be discussed later.

The Balint movement

The Balint movement[3] began in the early 1950s, as one response to the perceived inadequacy of the biomechanical model in general practice and the frustration of general practitioners. The National Health Service and other associated social changes led the misgivings voiced in the last chapter (*Lancet*, 1927) to surface. Despite their freedom as independent contractors, the conditions under which general practitioners had been brought into the National Health Service were unable to provide professional self-respect and job satisfaction. Payment was based almost entirely on capitation, so that the larger the list and lower the expenses the greater the doctor's income. This made it hard for even the most altruistic to develop reasonable standards of premises and staffing. The workload from a large list led to long surgeries of many brief consultations and there was a high visiting rate due to patient expectations and scarcity of private transport. This system gave little satisfaction to either the doctor or the patient.

The prestige of general practice was accordingly low. This was a period of boundless optimism about technology, with computers, space exploration and the analysis of the structure of DNA on the horizon, and resource limitations and environmental pollution undreamt of. The future of medicine was naturally seen in the application of this technology to disease. Although some (for example Huxley, 1950) sounded a warning note, more people shared Bevan's optimistic view that once medical technology had been applied in a just fashion, as the socialism of the National Health Service allowed, then: "In the future illnesses would be shorter and less severe; fewer people would die and fewer would become chronic invalids ... once the backlog [of ill-health] had been dealt with the need for medical services would fall." Hospitals were where this triumph against disease and death would occur, not general practice surgeries. It was during this period that Lord Moran (1958) made his famous allusion to general practitioners as "those who have fallen off the ladder". Every doctor was expected to aspire to be a hospital specialist and only those who failed to gain this prize would reluctantly accept a post in general practice.

An important response to this state of affairs was the founding of the College of General Practitioners in 1952. The Balint movement was a parallel attempt to solve the problems of general practice. It arose out of a series of seminars organized by Michael and Enid Balint, analytical psychotherapists, on the psychological aspects of general practice. The participants in these seminars developed a theory which Balint (1957) predicted would "sound rather shocking to some of my colleagues".

Shocking or not, it has become an important strand in general practice thinking, even though few general practitioners are actively involved in the movement (the current membership of the Balint Society numbers only 150). It attracted a number of doctors who went on to be amongst the most influential in general practice through academic departments, vocational training, and the Royal College of General Practitioners. This is not a work of medical history, and a detailed study of the way in which Balint ideas spread through general practice must await such a work, but a few examples will illustrate the process. John Horder, a member of the original group, went on to become both a leading member of the Royal College and was prominent in the development of undergraduate medical education in London, as were Paul Freeling and Malvin Salkind, members of later groups. Similarly the biographical notes of those involved in *While I'm Here, Doctor* (Elder and Samuel, 1987) and the other books show how prominent in medical educational circles Balintians have been. The present treasurer of the Balint Society is also secretary of the

[3]It is important to understand that Balint theory was developed by a group of general practitioners working with the Balints, not by Michael Balint alone, although the seminal book was published under his name. In this work ideas characteristic of the movement will be attributed to Balint, except when directly quoting from other authors within the movement, but this must in each case be understood as a reference to a school of thought rather than to Balint as an individual, important though his influence no doubt was.

Association of Course Organizers. Through these 'opinion formers' many Balint concepts have become part of the general intellectual milieu of general practice, influencing many who have never been to a Balint group or meeting, or read any of the books.

The key concept of this "shocking theory" was that "some of the people who for some reason or other find it difficult to cope with the problems of their lives resort to becoming ill ... they offer or propose various illnesses ... until between doctor and patient an agreement can be reached, resulting in the acceptance by both of them of one of the illnesses as justified" (Balint, 1957; p.18). In other words, illness cannot be dealt with solely in terms of the dysfunction of a machine but needs to be viewed in more human terms. It indicates the power of the biomechanical model and the weakness of general practice at the time that Balint and his colleagues first developed their ideas in terms of the analogy of the doctor as a 'drug', which like any other drug has its desired and toxic effects, and the possibility of idiosyncratic or predictable unwanted reactions. They argued that dosage and administration have to be calculated and understood, but unlike other drugs we understand little of its pharmacology, and it has not received the detailed study that had become the norm before the introduction of a new pharmacological agent. The aim of the Balint movement was to study that 'pharmacology'.

An empirical modification to the biomechanical model?

The Balint critique of the biomechanical model at first sight therefore appears to be empirical. Doctors had patients whom they could not 'repair' using the mechanistic model. The biomechanical doctor's "proper course ... to go on examining the patient until a proper organic cause could be found, and then treat the organic cause" (Balint, 1957; p.31) was not working. Either the patient did not get better, or he improved for a while and then the symptoms returned. This was the observation made in that general practitioner's handbook thirty years earlier (*Lancet,* 1927).

However, circumstances now made the problem more pressing. Under the list system general practitioners could not easily get rid of their patients, unlike the specialist who could establish that there was no problem within his field of expertise and so discharge them. Cost was no longer a barrier to the patient's attendance and the capitation system made the frequent attendance of such patients a burden with no financial recompense. The general practitioner therefore had to find some way of coping with them. The Balint movement offered a positive way of dealing with it. The psychoanalytic view suggests that it is not what appears to be broken that is the source of the problem, but something else instead. Symptom substitution and symptoms as symbolic communications are well known psychoanalytic concepts in psychiatric practice. In Balint these ideas find a new role in explaining the behaviour of patients who are not psychiatrically ill and indeed of explaining illness in general.

A major shift in values

That first group believed that their seminars revealed new diagnoses and treatment techniques which would work better than established ones, just as if they had literally discovered a new drug. Although their discovery included these empirical gains, more important was a shift in the centre of gravity of clinical practice from the disease onto the illness. The view of the doctor-patient relationship changed from that of an impersonal technician with a machine to a personal relationship between two human beings which helped the patient to deal with the illness, although not necessarily enabling the doctor to cure it in conventional biomechanical terms. Although Balint ideas were couched initially in terms of the drug doctor, perhaps in order to communicate with less innovative thinkers, before long this analogy faded into the background, and the doctor-patient relationship, undisguised in biomechanical camouflage, took centre stage.

The method chosen to develop the doctor's skill in this relationship was group discussion of cases, particularly those which made the doctor feel dissatisfied and uncomfortable. Therefore the work of the Balint seminars can easily be seen as a technique for a particular sort of problem; an additional interest to take or leave, like an interest in acupuncture or minor surgery. In fact although the focus of the Balint methodology is on the 'difficult case', where the biomechanical model breaks down, this emphasis on the doctor-patient relationship alters the way the whole of general practice is conceived. It implies a view of illness as part of life, a primarily hermeneutic aim for medicine, a less dualistic and mechanistic view of human nature,[4] and a teleological concept of life.

Integrating the illness into life

In biomedicine disease is separated from the patient, and a period of sickness is an interruption to life. The illness is externalized preparatory to cutting it off, literally in the case of surgery, and metaphorically with medical treatment. In contrast the Balint movement sees the illness as "part of the person" (Clyne, 1961) and speaks of the need to develop a "pathology of the whole person" (Balint, 1957; p.7). This is a metaphysical change with profound implications. Instead of being seen as a meaningless interruption to life, illness is viewed as an important experience.

Almost any symptom can be understood as an expression of psychological distress. This is fairly universally accepted now for the conventional psychosomatic disorders such as cervical root pain and back pain, headache and dyspepsia. Psychosomatic causation, however, strains the dualist metaphysic of biomedicine. Many lay people and some doctors schooled in this model assume that psychogenicity and demonstrable physical pathology are incompatible. In Balint both the traditional psychosomatic diseases and many others are interpreted in symbolic terms; cystitis, for example, as somaticized weeping (Julian P, personal communication), and chronic sinusitis as due to the retained tears of bottled-up grief. Even where the symptom has less metaphorical significance, illnesses are seen as reflecting a 'dis-ease' of the person with his or her state of life.

[4]This view has much in common with existentialist thinkers. In particular the doctor-patient relationship is in Buber's terms I-Thou rather than the biomechanical I-It. For a general discussion of existentialism, which demonstrates many features in common with Balint, see Macquarrie (1972).

The main aim of medicine is not to abolish the disease but to help the patient to understand the illness. It is for this reason that the term 'hermeneutic' (pertaining to the study of meaning) can be applied to the model. The goal of care is helping the patient to cope with an illness, and even to benefit from it, rather than trying to abolish it, by helping the patient to integrate it into a personal life narrative (Brody, 1990; Hunter, 1991) and come to terms with it. This implies a change in the status of illness and its place in life.

This does not exclude producing an objective change in the situation where that choice exists, but it is not limited to it and success is not defined solely in those terms. Subjective changes which improve the life of the patient are just as valid. Consequently the doctor's tools are not centrally the technological armamentarium of medicine, but the doctor-patient relationship as it develops in the general practice consultations. "The brief repeated encounters we have with our patients over the years represent virtually our sole arena, where almost everything we do as doctors is done ... 'while I'm here, doctor'" (Norell, 1987).

A move away from a rationalist view of personhood

Furthermore the consultation is understood not in terms of behaviour or rational cognition, in the way some psychologically or educationally oriented workers have done (e.g. Ley, 1977) but primarily in terms of the feelings of those involved. "What mattered [in a consultation] was that both were able to focus on feelings of life-long importance for the patient" (Samuel, 1987). The consultation is the patient's forum for coming to understand her illness; not merely a rational understanding, but an understanding which involves the emotions and which contributes to the growth of the individual.

In biomedicine patients come, as rational beings, to seek physical cure, or at least relief of symptoms. Their emotional reaction to and understanding of their illness is less important than the physical state of affairs. The term 'overlay' used to describe the psychological reaction to an illness seems to imply that this is less important and perhaps even less real. For the doctor to be understanding, compassionate and caring, are similarly extras, 'bolted on' as it were to the main business of the transaction, just as the patient's reaction to the illness is an extra 'overlying' the important concern, the physical disease.

To the biomechanical doctor a cure is the best goal. Where that is impossible then optimal relief of symptoms is the next best thing. Although the good doctor will comfort the incurable and those whose pain cannot be relieved, this is not the core of the doctor's role but the action of any minimally good human being. It is desirable icing on the cake of treatment, a work of supererogation. Whilst doctors can be sued for failing to take proper care in trying to reach the correct diagnosis, or for thoughtless prescribing, they cannot yet be brought before the courts for being uncaring, discourteous or failing to help patients understand their emotional needs. Interestingly whilst the legal system views the importance of these aspects of medical practice very differently, complaints about doctors are divided more equally between them, suggesting that the public holds both to be of importance.

In contrast, for the 'Balint doctor'[5] the focus is on making the patient feel better, whether or not this involves any objective change in circumstances. Feeling better is understood differently from the way it is understood in the biomechanical model, where improvement involves conforming more closely to a model of health conceived in terms of symptoms, morbidity and mortality. Although the Balint doctor may be pleased when such objective change is possible and treatment using the biomechanical model continues to be part of his medical practice, such treatment is also seen as a possible snare, a 'retreat into conventional medical care' which avoids a more important aspect of reality, the patient's interior life. Conversely the doctor using this model perceives it as success when the patient achieves a more satisfactory adjustment to an illness, even if his or her physical state cannot be objectively changed. This shift from a goal conceived in biological terms to one of psychological growth and adjustment is a fundamental shift in values.

The notion that a doctor's primary role is not to provide a cure but to help the patient cope with illness is not of course new. The epigram 'to cure sometimes, to alleviate often and to comfort always' is an ancient expression of this view. This orientation seems to have become somewhat obscured by the rise of the biomechanical model, which for the first time offered a possibility of curing often and thus led to the role of the physician as comforter and reliever being submerged by therapeutic euphoria. The Balints and their colleagues re-emphasized and systematized thinking on this aspect of medical care rather than discovered it.

The Balint model proposed a different concept of the proper concern of doctors partly because empirically it suggested ways in which the doctor could attempt to deal with problems which otherwise seemed intractable. Whether these work or not is largely irrelevant. They enabled the doctor to have a role perceived as useful in those cases where the biomechanical doctor merely felt uncomfortable, because it brought them into the range of things with which the doctor felt able to deal.

Thus for example the Balint doctor finds death, far from being a problem which it frequently is for the biomechanical doctor, one of the sources of greatest satisfaction. To help a person to face death, the ultimate existential challenge ("To die will be an awfully big adventure"; Barrie, 1904) is both difficult and rewarding in terms of this model. At the other extreme there is a new interest in the trivial, since the doctor will consider: "Why did this patient decide to come now with this problem rather than choose to self-medicate or ignore it altogether, as we know most people do for most minor and many quite serious symptoms?"

This shift in the scope and focus of medical care makes psychological issues not merely within the range of concern of general practitioners but their primary concern. Even when the patient has an illness which can be comfortably accommodated by the biomechanical model, the doctor's job is not finished when the corrections indicated by that model are instituted. The patient's response to the illness has also to be considered, and if it poses problems these should be addressed.

[5]There is in fact no such thing as a purely Balint doctor; as I indicated previously, these models do not correspond to the practice or thought patterns of individuals but are abstractions. The use of the terms 'Balint doctor', 'biomedical doctor' is, however, a useful shorthand for a doctor working according to the Balint model, and should be understood in that way.

One such doctor, Ian St George, in his farewell Speech to Otago Medical School, Dunedin in 1991, reflected: "Being honorary uncle [and understanding] generalness and friendliness, the willingness to deal with all that comes through the door, I was unprepared for as one trained in internal medicine in the hospital, but I soon learned to try to help people tackle the profound disturbances caused by rent increases, washing-machine breakdowns, the death of a budgie, as well as those caused by disease and death."

Underlying these changes is a different metaphysic of the human person and a change in understanding of the purpose of life. There is an implicit rejection of 'Enlightenment man' with his rational decision making, his mind-body dualism and the subjugation of feelings to reason which underlie the biomechanical model. Instead we have a model which draws from psychoanalysis. The image of the rational, emotionless patient making choices about medical care with the same care with which the prudent shopper chooses washing powder is replaced by the complex mixture of rational and irrational thoughts, emotions, drives and volitions, which psychoanalysis sees in human nature. From this switch follow new ideas about what patients are seeking, not a repair job, but friendship and understanding:

> What the patient wants of his doctor is to be befriended.
> (Norell, 1987)

> ... all our work is based on one human being ... understanding not only intellectually but in other ways as well ... intellectual understanding is not enough. (Balint, 1987)

> There are some people who need to carry someone around in their minds to use when they are under stress and the general practitioner may be used in this way.
> (Gill, 1987)

No more ghosts in machines

A non-dualist mind-body view is necessary for this understanding of illness. Physical events and psychological causes are intimately related. Whilst there is not a specific metaphysic of the mind-body issue in the Balint corpus, since abstract philosophical issues do not interest Balintians, the whole approach is antithetical to the mind-body dualism which underpins the biomechanical model. At times writers in the Balint tradition seem almost committed to idealism, evaluatively if not metaphysically. It is events in the mind which interest them, and they consider these more important than mere physical illness. This perhaps accords with Fulford's view that illness is primarily a mental, not a physical concept (Fulford, 1989).

A move away from individualism

The view of human nature is also less individualist than the biological machines of biomedicine. Although the doctor still mostly sees patients as individuals, literally in the consultation and metaphorically in that analysis is largely intrapsychic, they are seen as individuals in relationship with one another. This is a natural consequence of the nature of general practice, the caring for a number of people who live in close proximity, but it has a profound effect on the way the doctor perceives his responsibilities, particularly when people who are intimately related see the same doctor. Thus, for example, early in his writings Balint reports of his group:

> In the discussion it was agreed that in about one-third of the cases in which children are brought to the surgery by their parents, it is the parents who need treatment, that in another third both parents and child need treatment.
> (Balint, 1957; p.35)

This is a considerable broadening of the conventional notion of doctor-patient relationships. Balint, however, remains totally concerned with the individual who presents a problem to the doctor, and we are still firmly within the limits of the single doctor-patient relationship.

To the Balint doctor the goal of care is the personal growth of the patient. In this respect the model has more in common with teleological systems such as those of Aristotle and of Christianity than with the hedonism of biomedicine, where the goal is to give patients as long and pain-free a life as possible.

Note that the model does not conceive of psychological adjustment in Benthamite terms as maximizing pleasure or happiness. When in reply to a patient's request for understanding of his illness, a doctor says that the patient should not be concerned about the cause of his illness but leave it to the doctor to get it better, that doctor is criticized by the group (Balint, 1957; pp 22-3). The chief and most immediate thing patients come for is "the request for a name for the illness, for a diagnosis. It is only in the second instance that the patient asks for therapy, i.e. what can be done to alleviate his sufferings on the one hand, and the restrictions and deprivations caused by the illness on the other."

The concept of the doctor as teacher occurs often in Balint literature: "The doctor is a teacher who brings to patients an understanding of, among other things, what has to be borne" (Balint, 1957). The view of the doctor as first and foremost someone who helps patients to make sense of how to live is significantly different from being someone who helps bodies to go on working efficiently.

Thus we can see important differences in concepts of the human person, illness and the purpose of medicine between the biomechanical and Balint models. The understanding of autonomy, the nature of the doctor-patient relationship and even the view which the doctor takes of herself are also markedly different.

Attitude to autonomy

It is hard to define the attitude of Balint to autonomy. In one sense there is a very high doctrine of autonomy. It is the doctor's job to help the patient make sense of the illness, and the doctor and the patient work together on this. The doctor is the patient's friend, a far cry from the detached and sometimes patronizing professionalism of the biomechanic. "We [Balintians] prefer to wait to be consulted by patients where sufficiently troubled to seek outside help" (Norell, 1987). There is much emphasis on letting the patient set the agenda and working at the patient's pace. This is "patient-centred medicine" (Balint and Norell, 1973). It is non-interventionist, for there is seen to be merit in waiting for the patient to present the problem. This ensures that the patient is ready for the 'drug doctor' to have its effect.

Kelly (1955), whose concept of the psychotherapeutic relationship resembles the Balint approach in some ways, likens the therapist to the supervisor of a research student. The student/patient is guided by the specialist knowledge of principles and wider previous experience of the supervisor, but it is the student who actually does the work and makes the discoveries. Balint describes one case where the doctor notices a marked change in a situation from one consultation to another, which appears to reflect a highly productive conversation which "cleared the air" and which took place at home without the doctor being present, or directly instigating it. This is a far cry from the motor mechanic of biomedicine and appears positively to value and promote human autonomy.

On the other hand the patient is encouraged to enter into an unequal relationship with the doctor, similar to the transference relationship of analytic psychotherapy. The doctor does not necessarily accept at face value what the patient says but looks for the deeper, psychodynamic meaning. This insight is used to influence and promote change in the person's view of the world. Furthermore this is often done covertly, not through a straightforward psychodynamic interpretation, since this is not usually considered to be appropriate in general practice. This hardly seems a conventional respect for autonomy. Indeed Norell (1987) addresses the issue directly: "We rightly encourage self-help, but might there still be a place for 'doctor's orders'? Are there not some patients in need of paternalism at times?"

The difficulty with autonomy in relation to Balint arises because the rejection of the Rationalist model of human personhood makes inapplicable a concept of autonomy conceived in terms of interactions between purely rational beings. Once we move to a more complex model of the human psyche and consequently of human relationships, a less static, more teleological notion of autonomy is needed, incorporating the possibility of growth in personal autonomy and defining to what extent and in what circumstances it might be acceptable to make a short-term sacrifice of personal autonomy for the sake of a long-term gain. Unfortunately there has been little consideration of how such a concept of autonomy might work in practice.

The doctor-patient relationship

In the Balint seminar doctors examine their feelings about patients in the safety of a supportive group of colleagues. One result of this is the valuing of feelings as real and important rather than being seen as a sort of epiphenomenon of the more real physical illness. Perhaps an even more far-reaching consequence is that doctors are encouraged to see themselves as people with likes, dislikes and emotions in professional practice. Prior to this doctors had been encouraged both explicitly and by the example of their teachers to cultivate a professional detachment, to avoid getting 'over-involved'. This is necessary for the doctor, partly for emotional survival, to avoid being overwhelmed by the constant procession of human misery and suffering paraded before them. Also a measure of detachment is necessary in order to make a sound, rational clinical judgement. It is for this reason that it is generally considered unwise to treat one's immediate family and foolish to treat oneself — "the doctor who treats himself has a fool for a patient".

If the doctor is exercising an objective mechanical skill then there is in any case no merit in emotional involvement, and indeed little, other than a practical saving in the time needed to become acquainted with the details of the case, in continuity of care. The Balint movement, however, believes that it is impossible to avoid getting involved, particularly in the long-term relationships of general practice. They see benefit from such involvement. No longer is the doctor the outside observer. She is part of the system, using her whole person in the therapy. This involves a higher degree of involvement from the doctor. In particular if the doctor-patient relationship is one where the two individuals' feelings interact, then continuity is essential.

If the doctor is to take the risk of coming out from behind the impersonal mask of the biomechanic, then she needs other ways of coping with the emotional stress and avoiding this involvement damaging her and her patients. The Balint group is an important tool in this protective mechanism. There is a firm barrier in the Balint concept between professional and personal relationships. Whilst groups focus on feelings, and aim for the personal growth of the doctor, they do so only in the context of the doctor-patient relationship. Unlike trainee analysts undergoing therapy, the doctor is discouraged from using the group to deal with personal problems outside the consultation.

The use of the group for learning how to deal with these stresses helps account for the shift from individualism and rationalism. The insights which come from such a group make it hard to maintain the individualist Enlightenment model of the human person. Not only do the doctors realize that they are enmeshed with the patient, they recognize how both are enmeshed with other people, particularly the patient's family and the doctor's colleagues.

The crucial philosophical features of the Balint model are a shift away from a dualist individualist and rationalist model of human personhood to a more complex metaphysic, and the acceptance of illness as a meaningful part of life to be integrated into an individual's narrative rather than suppressed or removed.

Other similar models

Other teleological/hermeneutic views which do not accept the Balintian psychodynamic model share many of these features, for example cognitive and behavioural approaches to psychological problems (Markus et al., 1989). Although psychologists justify these therapies partly on the empirical grounds that they work better, they also value the fact that they enhance the patient's coping ability and increase their skills, not merely providing an external support which removes symptoms without altering the patient's abilities. Much health education work also places value on this sort of growth as well as on avoiding pathology (French, 1990).

This also applies to holistic medicine. A new emphasis on 'whole person medicine' sprang up in opposition to the biomechanical model in the 1980s. It enjoyed a brief period in the public eye, particularly perhaps because of the interest shown in it by various prominent public figures. It is difficult to be clear exactly what holistic medicine means, since it combines two concepts (Toon, 1986). One was a recognition that the biomechanical tradition was not able to solve all medical problems, and that other traditions may have

something useful to offer. The medical establishment has traditionally been hostile to 'alternative practitioners', partly from motives of professional jealousy and self-interest. There is also the problem that whereas access to the status of 'orthodox' medical practice is legally controlled, anyone can set up as an alternative practitioner, although this is changing slowly. There is no validation of the practitioner or of the proposed treatment. This together with a conservative rejection of anything unorthodox has separated these practices from conventional medicine.

One aim of holistic medicine was to promote a more sympathetic, though not necessarily uncritical, hearing to alternative or 'complementary' treatments and where possible integrate them into orthodox medicine. This is gradually happening, and it is no longer considered wildly eccentric to practise acupuncture, hypnosis, homoeopathy or osteopathy, or to refer patients to practitioners of those techniques, even if they are not yet within the mainstream of medical practice.

The other strand in holistic medicine was 'whole person medicine', that is, treating an illness as part of a problem in the whole of a person's life, rather than detaching it as a mechanical problem with the body to be fixed. This aspect of holism overlaps considerably with Balint's theories. Indeed Pietroni (1986), a leading figure in the holistic movement, asked the question: "Would Balint have joined the British Holistic Medicine Association?" His conclusion was that although Balint was probably constitutionally not a joiner or promoter of movements, the aims of the two were fairly similar.

Conclusion

The relationship between these movements, the Balint movement and other intellectual forces and shifts in opinion, is for our purposes unimportant. Balint stands as an example of this orientation, even if the model goes beyond it. What is important is the very different notion of good practice as integrating illness, promoting growth and valuing the personal aspect of medicine underlying these models.

CHAPTER 6

The "new kind of doctor"

THE THIRD model is also a reaction to the perceived limitations of the dominant biomechanical model. What Tudor Hart proposes as a "new kind of doctor" may also be referred to as the anticipatory care doctor. Numerous commentators (e.g. Illich, 1975; Black, 1982) have argued that despite technological advances and an enormous use of resources there is little evidence that curative biomechanical medicine has had a major impact on mortality and morbidity. It is suggested that the most striking improvements are due to simple and non-medical measures such as clean water, proper sewage disposal, and better food and housing. To what extent this view is correct need not concern us. A belief or a realization, depending on your view, that treatment-centred biomechanical technology was an unsatisfactory approach to many important illnesses has led to a new emphasis on preventive care, for instance in the Government's *Health of the Nation* strategy (Secretary of State, 1991).

The anticipatory care general practitioner

If waiting for illness to develop and then treating it does not work, a sensible alternative seems to be to try to prevent it. "Prevention is better than cure" and "a stitch in time saves nine" are well known aphorisms. Burkett, a surgeon with impeccable academic credentials[6] proclaimed this message in the 1970s, including in his talks a slide illustrating the futility of modern medical practice. There is a room full of running taps and overflowing basins and baths. Doctors in white coats are furiously busy with mops and buckets, trying to clean up the mess on the floor. It does not occur to anyone to turn off the taps. Burkett believed that it was about time that medicine should try to turn off the taps rather than merely mopping the floor.

If one accepts that prevention should receive a higher priority, it is clear that for industrialized societies this needs to be conceived differently from nineteenth and early twentieth century public health, since the problems are different. The major causes of illness and death are not infections requiring structural work, such as sewers and a pure water supply, but diseases the prevention of which require changes in individuals relating to personal choice of lifestyle (tobacco smoking, alcohol consumption or sexual practices) or medical actions on specific individuals, such as immunization, cervical cytology, or blood pressure control.

[6]Burkett established a firm reputation in biomedical research by being one of the few living doctors to have described an important new disease (Burkett's lymphoma). See the obituary in *The Independent* of 3 April 1993 for a synopsis of his other achievements.

This is a difference in degree rather than kind. Education of the population in the causes of water-borne disease was needed alongside the provision of potable water. Also, although most of the diseases of poverty which still plague the Third World are rare in the UK, the Black Report (1982) demonstrated that there is still a solid link between poverty and illness. Housing, employment and income are important determinants of health, and some would argue that public policy measures are still the most effective way to improve the public health. Whatever the merits of these arguments, in practice the main responsibility for prevention of illness has been laid on individuals, doctors and patients in recent years.

The balance between preventive and curative activity is an argument about the role of health care as a whole, not specifically of general practice. If, however, the way to promote health is seen as by individual intervention, it is obvious that general practice should fill this role in Britain. The work needs to be done by people who can easily make contact with those individuals. General practice has health professionals distributed evenly all over the country. Virtually the whole population is registered with general practitioners. This system produces practices of between 2000 and 20 000 patients, a manageable size for organizing screening, immunization and health education programmes. The definition of general practice is so elastic that it can be stretched into almost any shape. As is so often suggested, "the general practitioner is ideally placed ..."

Some preventive work has a long history in general practice. Antenatal care and immunization date from before the beginning of the NHS; cervical cytology and family planning became a *de facto* part of general practice more recently, particularly after the General Practitioner Charter of 1966 made them financially attractive. Making other aspects of anticipatory care more central was a shift in emphasis rather than an innovation.

The concept has become established rapidly. It was only nine years from the College manifesto on health and prevention in primary care (RCGP, 1981, 1982) to the 1990 contract, which made this the only aspect of general practice which is strictly defined and compulsory. During that period many initiatives, conferences and research papers appeared on the theme. Examples of such work include the ACT conferences and many research papers.

This is a model which underlies the views of many people, but is more often assumed than stated. Tudor Hart is an exception. The openness and clarity of his writing make his work, particularly *A New Kind of Doctor* (1988), the most obvious source for defining the philosophical basis of this model. In a sense this is misleading, since although he is a great proponent of the model, he explicitly rejects some of

its implications which are widely accepted, and some of his core beliefs are personal rather than essential to the model.

There are other proponents, notably a group of general practitioners and others based around the Oxford University Department of Public Health and Primary Care. They have launched a campaign to make prevention and audit part of general practice by the promotion of prevention nurses and anticipatory care teams. They have been highly influential, and their methods have spread far beyond Oxford. They were probably a major influence leading the Government to make preventive activity mandatory for general practitioners in the 1990 contract, but their aims have been shared by many other projects and organizations. The Royal College of General Practitioners (1981, 1982) has also promoted the idea that the general practitioner should become more prevention-oriented in its *Reports from General Practice 18-21* and other policy documents. Many similar projects began around the same time. "Heartbeat Wales" was a government-sponsored campaign linking primary care, public health and voluntary services in a coronary prevention campaign, which was in some respects a sort of forerunner of *The Health of the Nation.* An example of a more local initiative is "Healthy Eastenders", a co-operative project between a number of practices in Tower Hamlets, co-ordinated by Dr John Robson, who shares many of the ideals of Tudor Hart and could perhaps be described as a 'disciple' of his. Many other projects in other parts of the UK have adopted a similar approach.

Yet more empirical modifications

As with the Balint movement, the initial motivation for the shift from biomechanical approaches was empirical. This is Burkett's argument — that treating established disease is not efficient and in many cases not effective; perhaps prevention would be a more effective means to the same end. It was not perceived as a change in values but merely a different method. Thus Tudor Hart (1988) states: "If medical science is to be delivered effectively to the people ... anticipatory care ... must become the heart of good practice." He sees pro-active care as the best way to improve morbidity and mortality by early diagnosis and by decreasing risk factors.

Although less naïve than Bevan, acknowledging that pro-active care is expensive not money saving, his basic premise is similarly optimistic. It will be cheaper in the long run, or at least affordable value for money. He observes that reactive care is stable and may even decline. Proactive care will take up and can exceed the slack, if well done. Similarly the Oxford project is based on the empirical assumption that this is an effective and affordable way to reduce the mortality and morbidity from heart disease.

Empirical problems with the model

There is continuing debate about these empirical assumptions. The first issue concerns effectiveness: can the methods of individual intervention suggested by the model really change the natural history of illnesses, prevent morbidity and postpone death? Clearly we need to ask the question separately for each condition.

There is often little empirical evidence of success in affecting disease rates, even with well established screening techniques such as cervical cytology. However this could be because we have not tried hard enough or in the right way, rather than because the enterprise is ill-conceived. The long time for preventive measures to affect disease rates, and the innumerable things which can happen in the meantime which may affect the outcome, make this a particularly complex area to research.

Even if it can be effective, this road is not easy. Most of the desired changes do not rely merely on changes in doctors, nurses and NHS organization but also require patients to work hard. Even attending for screening tests requires a commitment, and uptake on the whole has not been impressive. Many practices find it difficult even with great effort to obtain cervical smears from 80% of women, the current higher target. Even when this target is achieved it can mean that 20% of women are not having a test which in principle can totally prevent a fatal illness. Where the benefits are less clear and the illness less serious it may be even harder to persuade people to put health promotion at the centre of their lives.

To make things worse, many of the really important gains are to be made not from medical tests where the patient is passive, but from behaviour changes which require an active commitment from the patient. Success in giving up smoking or making changes in diet depends on people wanting to make such changes, as well as assuming that they can do so with appropriate help.

Secondly there are debates about costs. There is a common empirical assumption that this policy will be more cost-effective than reactive care — in Burkett's image it is less effort to turn off the taps than to mop up the floor. The calculations of the cost-effectiveness of such preventive intervention is very complex. It involves costing the time involved in screening and treating risk factors when they are found. Whilst some elements, such as drug treatments for hypertension and hyperlipidaemia, are easily assessed, factors such as the time of general practitioners and practice nurses are not routinely costed or easily divided up, since the work is done as part of a more general service. Even the drug costs are complex, since they can vary enormously according to what drug regime is chosen. Also the unit cost may fall as the level of prescribing rises and drug costs fall.

The effectiveness of an intervention in decreasing risk also needs to be assessed. Is a cheap intervention with a low success rate better than a more expensive one which is more successful? Is it better simply to tell all my patients to stop smoking, knowing that only one or two will heed my advice, or to work more intensively with a few people who seem more likely to succeed?

Finally the costs of treating the illness reactively rather than preventively have to be considered, and also the indirect costs to society, such as loss of productive capacity or the need to support dependents when the bread-winner is disabled or dies prematurely. Furthermore none of this takes account of the vexed question of how much financial value one can put on saving a life or avoiding human suffering.

It is therefore hardly surprising that there is little consensus on which preventive programmes are cost-effective — if indeed any are. Some have argued that pro-active care that was well done would not just exceed the slack in medical resources (if there be any) but break the elastic. Others have

argued that despite the individual nature of the problem, success in epidemiological terms may require a population-based strategy rather than individual interventions. For example, the level of cigarette smoking may be more effectively lowered by an increase in tobacco tax and bans on advertising and sponsorship than by a host of doctors and nurses trying to help individuals to give up. If we want to lower serum cholesterol then taxes on high fat foods may be a better way of doing this than dietary advice and cholesterol-lowering drugs.

We do not have to answer these empirical questions in order to analyse the philosophical implications of the model. Whilst it may not be right to adopt this model if it is not cost-effective, the converse does not follow. Just because we can choose this type of general practice and it will achieve our goals, this does not make it right to do so. Does such work constitute good general practice?

The values of the anticipatory care model

In many ways the philosophical assumptions are the same as those of the biomechanical model. It holds to the dualist, rationalist eighteenth century model of human nature described in Chapter 4. The concept of health is similarly mechanistic; that is, the good working of the physical machine for as long as possible. Fullard's adoption of the term 'human MOT' for her highly successful campaign to promote cardiovascular health checks is a clear demonstration of this (Fullard et al., 1987). This was a quite deliberate use of the mechanistic, car mechanic model. To pursue the analogy, the change from traditional biomechanical medicine to anticipatory care is equivalent to a change from driving along until the car breaks down to having twice yearly services and regular oil and water checks.

Unsurprisingly, therefore, the model retains an Enlightenment faith in the scientific approach as an adequate solution to medicine's problems: "Medical knowledge ... should remain the main source of innovation in general practice" (Tudor Hart, 1988). The shift is merely a tactical change of direction on the march to biomechanical triumph, not a defeat or a change in the nature of the game, as Balint was.

The change does, however, have evaluative implications. Central to the model is the objective of maximizing health, measured by such traditional epidemiological markers as death rates and perinatal mortality rates. It sees the general practitioner with the defined population as the ideal unit to work with individuals on this process. "If medical science is to be delivered effectively to the people, anticipatory care must stop being regarded as an optional extra ... it must become the heart of good practice. If the terms and conditions of GP service discourage this they must be changed" (Tudor Hart, 1988; p.123). The general practitioner list can be seen as an epidemiological denominator. It enables both outcome and process to be studied in terms of success and failure (what we have not done), which is something no other unit can do so easily. "Registered patient lists made possible a scientific approach to management of illness in society ... GPs could ... relate the cases they saw to the local populations from which they came" (Tudor Hart, 1988; pp 98,99).

Individualism and the good of society

Although illness and health are conceived in the same mechanistic terms as in the biomechanical model, the focus has changed from the individual to the population. It is hard to reconcile this community-based value system with the traditional response to individual need. Philosophically this is a major shift from the biomechanical and Balint models, which are both firmly anchored in the individual doctor-patient relationship. This fundamental value shift accounts for most of its other major features and brings us to a familiar conflict in moral philosophy.

Ethical systems are often divided into deontological, where what is right is conceived in terms of respecting the rights of the individual and fulfilling the duties of the agent, and consequentialist, where the aim is "the greatest good of the greatest number".

The individual doctor-patient relationship in the traditional biomechanical model, which Tudor Hart refers to as Oslerian, is deontological. This is largely unaltered in the Balint model. Although there is dispute about the philosophical basis of the doctor-patient relationship (see Chapter 7), most people conceive of it in terms of patients' rights and doctors' duties, with respect to care, confidentiality, informed consent and so forth. Although doctors clearly aim to benefit their patients, this is limited to the individual who asks for it and to those benefits which that person seeks.

In contrast public health operates in a consequentialist way, taking as its aim the greatest good of the greatest number, without particular concern for specific individuals. The goals of the *New Kind of Doctor* are more akin to public health than the traditional clinician responding to individual demand. The model is consequentialist with goals set in group not individual terms. Since we are dealing with risks and rates this is inevitable.

When these two activities were carried out by separate people in different organizations they could co-exist, the contradictions between them not becoming apparent. Once, however, a public health agenda is proposed for general practice then these conflicts, in particular the difficulties a consequentialist model poses for respect for autonomy in individual relationships, become more obvious.

Attitudes to autonomy

A problem arises with traditional notions of autonomy from the emphasis on group outcome and process measures. In prevention of disease it is necessary to use group measures to audit the quality of the work being done. Use of this model, therefore, can infringe Kantian notions of autonomy in two senses. It puts an abstract notion, the disease and its rates, rather than the patient at the centre of attention. The patient thus becomes a means to the end, which is the defeat of the disease, not the good of the person who has the disease. This point is often made by doctors who claim that we should aim to treat patients, not diseases. The displacement of the patient by the disease can also occur in the biomechanical model. We are all familiar with the joke that "the operation was a success but the patient died". Any model which encourages doctors to focus on abstract rather than patient-centred goals can fall prey to this tendency.

When, however, we adopt the anticipatory care model the

focus is further removed from the individual. In the biomechanical model the focus was entirely on the individual patient and it was her disease which was being treated, even if not she herself. Not only now is it the disease and not the person which is the centre of attention, but it is disease in the community rather than disease of the individual which is the measure of success. Individuals are therefore merely means to the common good. A natural result of this is pressure on the individual to comply in order to make the figures satisfactory. This issue needs to be addressed by any system which aims to promote good practice through the use of audit and group outcomes.

An example of such a conflict is the introduction of target payments paid to general practitioners who take smear tests for cervical cytology from greater than a certain percentage of their target population. For public health success this target is defined in absolute terms, excluding only those who could not benefit from a smear, such as women who have had hysterectomies or who have never been sexually active. Those who decline the offer of a smear are not excluded. In consequentialist terms this is right. In the more conventional duty of care model, the patient might have the right to expect her doctor to do a smear, but the doctor's duty would be discharged by offering it, and the patient would have the right to refuse it — a right which the doctor must respect.

Although the turmoil which was predicted — unwilling patients being coerced into smears, or doctors unwilling to infringe patients' autonomy refusing to try to achieve targets — does not seem to have occurred, we do not know what is actually happening. Whether patients are being coerced but are accepting this passively; whether doctors are managing to hit targets merely by providing a service to the willing; or whether they are casuistically defining those who are not willing as "not indicated" (since according to liberal views how can it be indicated to do something to a patient which she does not want?); or whether a mixture of all three possibilities is happening is not clear.

This subsuming of the individual in the common good applies even more to risks and rates of immunization, where herd immunity is an important aspect of success, quite apart from arbitrarily fixed targets. The same applies to some extent to tobacco smoking, where the individual's behaviour affects risk to others through passive smoking and not just himself/herself.

The argument applies equally to other health promotion activities where the doctor is rewarded for carrying out a procedure not requested by the individual. It points up the difficulty in a consequentialist model of reconciling beneficence conceived in population terms with respect for individual autonomy. Since the benefit of health promotion will of necessity almost always be statistical, there will always be some, often the majority, who undergo procedures or make changes to their lives which will not benefit them.

Reconciling responsive and anticipatory care

Just as the Balint orientation raises the difficulty of drawing the line between Balint and the traditional biomechanical model, it can also be hard to reconcile response to need with anticipatory care. One solution has been to put in extra resources in the form of prevention nurses so that traditional reactive work done by doctors can go on unhindered. However, when seeking to induce patients to take up opportunities for anticipatory care it has been shown in many studies that 'working it in' to a patient-initiated consultation is the way most likely to get a high level of co-operation. Tudor Hart (1990) states this quite clearly:

> *Above all* [my emphasis] consultations prompted by personal choice provide more effective opportunities for proactive care.

In the light of the above discussion the question must arise whether taking the opportunity provided by a patient's consultation to deal with an issue on the doctor's but not the patient's agenda is an infringement of the patient's autonomy. Certainly if it is not this presumes a different concept of patient autonomy from the 'hands-off' impartial model implicit in the Oslerian models of biomedicine and Balint.

The doctor-patient relationship

Like Balint but in a different way this model gives scope for almost infinite medicalization of life. Since in its terms health is affected by most of the actions in our life, there is a real possibility of the doctor becoming the platonic philosopher-king, laying out rules for the whole of life. Although there may be ways of avoiding it (Toon, 1987; Tudor Hart, 1988; ch. 9) there is a tendency inherent in the model for paternalism and even authoritarianism. Tudor Hart (1988) recognizes this implication of his position and is clearly unhappy with it: "Doctors must still respond to demand, for this is the only ultimate guarantee that patients' wants will be included in the medical definition of needs ... their definitions of what is important have ultimate priority over the opinions of doctors" (p.121). But he is too logical to escape the ultimate conclusion that doctors' actions must "depend less upon symptomatic demand and more upon perceptions of need, which initially at least must be medical perceptions" (p.121).

The relationship between doctor and patient differs between the various activities important in the promotion of health according to the anticipatory care model. They can be divided into immunization and screening on the one hand and health education on the other. In screening and immunization the relationship is like the biomechanical one where the active expert acts upon the passive patient, but unlike the Oslerian paradigm it is not left to the patient to set the agenda. In health education the patient must play a more active role. Tudor Hart appears to have this in mind when he defines the doctor-patient relationship as one of equals: "We must accept patients as colleagues in a jointly designed and performed production, in which they will nearly always have to do most of the work" (p.316). Unlike the passive body-machine being mended by the all-knowing doctor while the patient stands impotently watching, the patient needs to take an active part in the repair process.

However, in both cases goals are set in medical terms. The patient as it were assists in wielding the screwdriver in health education, but the doctor decides what maintenance programme is necessary. The goals (unlike the biomechanical or even to some degree the Balint doctor) are not limited to dealing with problems presented and defined by the patient, but are concerned with finding, changing and avoid-

ing risk factors for diseases the patient may never even have heard of. These goals are phrased in doctor (disease) terms rather than patient (illness) terms. "People do not in general demand treatment for causes of diseases they don't yet have" (Tudor Hart, 1988; p.122).

Thus the doctor is clearly defining what is good for the patient. It is assumed that if the patient were in a position to make the judgement, they would decide in favour of preventive care since this is the judgement the reasonable person would make. This is of course the classic justification of paternalism.

This is a different sort of paternalism from that of Osler or Balint. In a way it is more inescapable, since it has to be the doctor who defines the goals; only she has the knowledge to do so. The shift towards consumerism which can provide an alternative to paternalism for the Oslerian model is not available in this model. The patients must be bossed around to be healthy. There is no room for a free and informed decision to smoke and risk heart attacks. This will be perceived as failure just as much as not providing a cure is for the biomechanical doctor.

The patient can say no, and when it comes to behavioural changes such as giving up smoking, most do so. Thus the degree of paternalism should not be exaggerated. Effective intervention of this type requires that the doctor gets the patient on his side; perhaps this is what it means to say that the patient must become a co-producer of health care. On the other hand the pressure on the patient cannot be ignored. Nor can the question of whether it is right for the doctor to use her influence on the comparatively vulnerable patient in this way. The effect on the doctor of a change in orientation which comes from constantly thinking of rates of immunization, blood pressure measurement and taking cervical smears, and not of the needs of the individual patient may lead to a considerable change in the nature of her practice. We must consider whether this is something which we desire or not.

Another feature of this model typical of consequentialist ethical systems is that the doctor's responsibilities have no limits. In a deontological model, although it may be hard to complete one's duties there is always a hope that one can do so. In a consequentialist system there is no such possibility. There are no works of supererogation, and one can never feel one has done all one could. This has both advantages and weaknesses. It may lead doctors to try harder and achieve better results, but they may become over-stressed and despondent, which does them or their patients little good. Alternatively they may place pressure on their patients to conform to the medical image of health, which may not accord with the patient's aspirations.

Justice in the model

An interesting and complex issue is the place of justice in this model. The previous models had little intrinsic to say on the subject. Reading Tudor Hart one rapidly notices that in contrast justice is central to his thinking. This, however, is a result more of his political views than the model.

He is an ardent socialist, and his view of the "new sort of doctor" is shot through with socialist ideals of public accountability and community. However, the shift from reactive to anticipatory care has been espoused by others with markedly different politics. The leaders of the Oxford project, although highly enthusiastic, breathe an air less fiery than the coal-dust laden fumes of Glyncorrwg, but their medical model is similar. Their use of nurses (mostly female) rather than doctors (mostly male), largely on grounds of cheapness, and their frequent appeals to the profitability of prevention by increasing smear and immunization fees, would certainly not commend itself to egalitarian, anti-sexist socialists, and suggests that the model is compatible with political views other than those of Tudor Hart.

This is emphasized by the boost to this model given by the Conservative Government which introduced the 1990 general practitioner contract, with its targets, health promotion clinics and compulsory health checks. Prevention in general practice is not a socialist monopoly and does not require any political creed. Nor does it require any particular view of justice or just health care resource allocation, although these will clearly affect the way in which it is implemented.

Other socialist suggestions of Tudor Hart which may or may not be commendable are also not essentially part of the model. For example, he proposes organization in ways which promote direct accountability to the local community. However, the 1990 contract made general practitioners accountable for preventive duties to Central Government via unelected appointees. Similarly Tudor Hart favours redistributing resources towards those most in need. There was, however, no suggestion in the 1990 contract of policies aimed at redistribution of health care resources to the disadvantaged, unless one counts the requirement to invite non-attenders for health checks. The new allowance to general practitioners working in deprived areas was not tied to prevention. It was an attempt to deal justly with general practitioners working in difficult areas with respect to their colleagues in more affluent parts, rather than an effort to target health care resources to the most disadvantaged.

These issues of justice and accountability are therefore not essential parts of the model. Indeed the model has been criticized as unjust as well as uncharitable (*Independent on Sunday*, 1992) because the emphasis on individual change as the means to improvement of health in practice does little to help the most disadvantaged. They are often least well placed to take advantage of the services offered.

Public health and general practitioner roles

Tudor Hart suggests that general practitioners should be concerned with local public health issues in ways other than by working with individuals, as a sort of local medical officer of health. This idea is of considerable practical and philosophical interest. Empirically there is much to commend it. We know that social factors play a major part in affecting health. It may be that the most cost-effective anticipatory care is work with communities rather than individuals. Whether the general practitioner would do this better than other public health structures is as yet unproven.

Ethically this may avoid some of the difficulties of individually-based preventive care, since the doctor would not have the conflict between patient and doctor agenda in the consultation. The doctor would do two separate but linked jobs, providing a demand-led, patient-centred service part of

the time, and spending the rest addressing issues related to health in the local community in a quasi-political way. Each role would inform the other, but the element of intrusion and coercion in the consultation which has been criticized in the anticipatory care model would be absent. It would still be necessary to decide what proportion of time it was right to spend on each sort of activity, but this would be a more tractable problem than dividing time and attention between the doctor and the patient's agenda in each consultation. No doubt, however, if implemented we would find that such a brief would raise peculiar moral difficulties.

Conclusion

In any case it is the anticipatory care model centred on the individual promotion of health which is currently influencing general practice. Like the other models this implies its own concept of good practice which arises from assumptions about the nature of humankind, illness and disease, the role of the doctor, and the purpose of life. The anticipatory care model is not an answer to the question of what is good general practice, it merely adds another option, making the question harder to answer.

CHAPTER 7

General practice as a business and patients as consumers

THE MODELS so far defined each has a concept of illness, human nature, and the purpose of general practice, and hence of what it would mean to do it well. Whilst the relationship between doctor and patient differs between the three models, its existence is taken for granted and its basis not questioned.

There are in fact various views on the nature of the doctor-patient relationship, which has been variously described as a contract, a covenant, or a relationship of beneficence.

Theories of the doctor-patient relationship

The notion of a contract draws on legal parallels. The doctor and patient agree with each other that the one will offer a service and the other provide payment, directly or indirectly via State or private insurance. Each party, as with any contract, has rights, duties and a role to play.

In the context of general practice whatever the responsibilities of the relationship might be it is clear to whom it applies: people who have registered with a doctor or practice for general medical services under the NHS. Even the temporary or once-only patient quite explicitly enters into this relationship by signing a form, without which the general practitioner cannot receive payment. That care is offered as part of a contract is also explicit in the general practitioner's Terms and Conditions of Service (DoH, 1990; NHS, 1992). These documents can be seen as the foundation of the relationship between the general practitioner and the patient. Under the biomechanical and Balint models it is only 'activated' when the patient presents with a problem, whilst in the anticipatory care model, and under the 1990 contract in law, registration imposes actual as well as potential obligations on the doctor. The contract model therefore has face validity.

A covenant is similar to a contract, but rather than drawing on legal analogies it stems from the world of religious thought. A covenant is a solemn promise with a moral basis. It is the foundation of a relationship which the parties enter into voluntarily, but are thereafter committed to and must work at and give themselves to freely, in contrast to the minimalist interpretations commonly given to legal contracts. It places more emphasis on the relational, human relationship and less on the cut and dried exchange of services for money. This soft, almost mystical interpretation is of course most obviously compatible with the humanist models discussed in Chapter 5.

Both covenant and contract imply a deliberate if not necessarily explicit agreement between doctor and patient implying a reciprocal relationship with responsibilities and rights on each side. In either case there is an agreement, and thus some basis on which one can define people as either being patients or not being patients. In contrast the model of beneficence makes no distinction between people according to any implicit or explicit agreement or contract. The doctor and patient are joined by "the bond of need" (Pellegrino and Thomasma, 1988). The doctor's responsibility is to try to deal with need wherever she finds it. This model is essentially consequentialist, defining what one ought to do by results. Like many consequentialist models, and unlike the contract and covenant models which are deontological, it implies no clear limit to the moral responsibilities of the doctor. She is required to try to comfort, protect or treat all those with whom she comes in contact, not merely those who are on her list.

Which model we accept will affect our view of what it means to be a good practitioner. The most widely held, and for British general practice probably the most credible, is the contract, since it reflects the real situation. However, the doctor-patient relationship has traditionally been viewed in moral terms, more compatible with covenant and beneficence models. Medical codes such as the Hippocratic Oath and the Declaration of Geneva (BMA, 1980) view issues in this light, although the former has recently been re-written as a contract (Rosalki, 1993), apparently satirically. The notion of 'vocation' stresses the moral responsibilities of doctors to their patients. Medical contracts have often been analysed in terms of a moral theory of promising rather than a legal theory of obligation.

The last decade has, however, seen a worldwide growth in emphasis on the market. In Britain we have had Thatcherism, whilst similar policies have been followed by the Reagan administration in the USA and 'Rogernomics' in New Zealand. We have seen the fall of State communism in Eastern Europe, the former Soviet Union and much of Africa. Alongside this has grown up a patients' rights movement closely linked intellectually to the consumer movement. As a consequence it has become more common to see the patient as a consumer and the doctor as someone running a business. This has been reflected in the recent reorganization of the National Health Service.

General practice as a business

Certainly general practice can be seen as a service industry, with lots of small businesses. General practitioners receive fees from the family health services authority to provide the service, and are required to provide staff, premises and equipment to do so. They do not earn a salary but take the profits from providing this service to live on. There is a con-

siderable literature on general practice as a business; *Medeconomics* and *Financial Pulse* both reflect the view that the purpose of general practice is maximum profit, as a glance at any issue will demonstrate.

This contrasts with literature from bodies such as the Royal College of General Practitioners and the learned journals. In these the discussion often seems to see doctors as platonic gentlemen of independent means, with no need to work or think about money: their sole concern is to decide morally and empirically how best to occupy their time. This unworldly view (which it must be admitted has probably also characterized the present work so far) is reinforced by the English tradition that it is ungentlemanly to talk about money and unladylike to pay for anything, and by donnish attitudes in moral philosophy. Philosophers rarely see their moral agents as having needs of any sort, financial, emotional or physical.

Reading the moral and professional literature and the business literature of general practice it often seems that they exist in different universes, with no contact between the two. The problems which arise when maximizing profits and benefiting patients conflict receive scant attention from either side. If we wish to develop a realistic concept of good general practice, we must examine the relationship between the business nature of general practice and our aspirations to high quality care. As with our previous discussions, we must distinguish between empirical and evaluative debates about the business aspect of general practice. It is an empirical matter whether the organization of general practice as a business is helpful. This system is not part of the renaissance of capitalism of the 1980s. At the start of the National Health Service hospital consultants accepted salaried status in return for a generous financial settlement, referred to by one politician as "having their mouths stopped with gold". General practitioners in contrast contracted with the Government to provide health care, including facilities and support staff as well as their labour, for their registered patients. General practice was thus 'privatized' long before privatization became fashionable.

Empirical benefits of the system

The 'independent contractor status' has always been jealously guarded by representatives of the medical profession. Critics of the arrangement have attributed this enthusiasm to the financial benefits of being taxed as self-employed rather than under PAYE. This, however, is probably unfair. Many of the benefits foreseen in other privatization programmes apply to independent contractor general practice when it functions well. Small independent units can be efficient and flexible (Jones et al., 1981). Decisions can be made and implemented quickly, free from the stranglehold of a bureaucracy which can make effecting the simplest change or repair in hospitals a nightmare.

This freedom has enabled general practice to develop in ways which would have been impossible in a large organization. For example, the rapid growth of practice nursing in recent years, both in numbers and in the range of services offered (Bowling and Stilwell. 1988) contrasts with the stagnation of the parallel community nursing roles of health visiting and district nursing run by health authorities. General practitioners have been free to make their own decisions about what type of nurse to employ, and what tasks to ask them to undertake. They are subject only to the medico-legal responsibilities of the doctor and nurse as autonomous professional people, unhampered by complex regulations and supervision. This allows the best use of the different skills and aptitudes of individuals and the system can respond flexibly to the needs of different populations. Despite occasional disasters (for example the case of a nurse incorrectly taking cervical smears revealed in Birmingham in 1993; Hunt, 1993), this has on the whole worked well, since most doctors and nurses behave sensibly when they are given responsibility.

General practitioners are encouraged to use their staff efficiently and to keep costs down, since the higher their costs the smaller their profits and hence their take-home pay. Savings made can also be carried forward and used for future investment. This contrasts with a profligate system in the public sector whereby until recently the individual controlling a budget had little interest in making savings, and indeed in practice was discouraged from doing so. Not only is any money unspent at the end of the year sacrificed rather than saved for future years, but also underspending can lead to a cut in future budgets. Byzantine regulations prevent savings in one area of spending being used for improvements in others. Thus in addition to poor cost control because administrators and clinical staff have no interest in economy, the system leads to an orgy of consumption each February and March when money left unspent is often frittered away on items of dubious value. Recent reforms have attempted to deal with this problem, although it is not yet clear how successful they are.

There are also drawbacks to the system. Although making general practitioners responsible for their expenses encourages desirable thrift, it can also encourage undesirable meanness. A doctor who provides a pleasant, comfortable and well equipped surgery, employs a good range of staff and is available for long hours may offer a better service than one who works with the minimum of support in cramped and dingy premises, opening for the shortest time possible and spending the rest of the time doing other work. It is however quite possible that the second doctor's profits will equal or exceed those of the first. This problem was particularly evident under the original 1948 system, and was a major reason for the pressure from general practitioners for the 'Charter' changes of 1966. Although these ameliorated the worst features of this inequity (at some cost, it must be said, to the general practitioner's independence) the problem remains (Inkley-Leitch, 1993). In part this is a consequence of the vague and open nature of the general practitioner's contract. This means that only in the most extreme cases of inadequate provision can the family health services authority take any action to enforce its contract. There are few mechanisms, except for item-of-service payments in a few narrow areas, for rewarding different levels of service differently.

The "good practice allowance" (RCGP, 1985a) would seem a reasonable attempt to solve this problem. In fact the proposal met with widespread hostility from general practitioners and did not form part of the 1990 reforms. One possible reason for this surprising response (from practitioners who one might have expected to have benefited from it as well as those who would have lost money) is that doctors feared having a concept of good practice which did not

accord with their own imposed upon them — which is a natural consequence if my thesis that there is not one model of good practice but several that differ in fundamental philosophical ways — is correct.

General practitioners as competitors

A perceived benefit of the business model which has been promoted in recent years is that competition is encouraged, thus promoting good quality service and efficiency by the operation of market forces. Changes to the general practice contract in 1990 were in part designed to encourage this. There is a flaw in applying this argument to general practice, where better service does not usually lead to more customers and bigger profits. There are limits to the capacity of any practice or practitioner. Unlike most small businesses, which can take on more staff, move to bigger premises and so increase the profits of those in charge, there are firm constraints on general practices taking this road. First, the payment structure encourages this only to a very limited extent. More income can be generated by employing nurses and assistants and delegating tasks to them, but after a certain point if a doctor takes on more patients she has to work harder. Secondly the partial direct reimbursement structure makes this expansion less attractive than it would be in a true free market. Thirdly there are frequently practical constraints. A general practice, unlike a factory, cannot relocate to larger premises in another town; a move of half a mile may be difficult.

Finally the organization of the payment system for general practitioners prevents the free operation of market forces. Under the intended net remuneration system the Government decides how much a general practitioner should earn, with the advice of an independent review body. Fees are then set at a level designed to give the average general practitioner that level of profit after expenses. This is quite a different method of pricing from any which operates in the market, since if general practitioners offer more services, and 'increase the size of the market' the price per item of service falls to maintain the overall average level of profit. It was widely attacked by general practitioners after the introduction of the contract in 1990 when, because they earned more payments than expected (i.e. worked harder) the Government claimed that they had been 'overpaid' and suggested that the money be reclaimed in subsequent years. Although because of political pressure this did not in fact happen, the incident demonstrates that under the present system general practice does not operate truly according to market forces.

Perhaps the most important factor is that our culture does not favour this road. Whilst it might be nice to suggest that general practitioners would see increasing profits by the use of nurses and assistants as exploitation, this is probably not the barrier to expansion. More significant is that general practitioners mostly want to do general practice, and not to manage a large business where other people do the practical work. A recent article made the comment that the author did not go to medical school to become a supermarket manager (Berwick, 1992). Thus 'good practices' in business terms — that is, popular ones with a large potential market — restrict their workload by refusing to take on additional patients. Alternatively they expand by taking on new partners, who generate more income but also increase the number of people to share it. Thus profits per partner only increase in line with any economies of scale which this yields.

Similarly patients do not generally behave towards their general practitioner as they do to providers of other services. Attracting customers and customer loyalty is important to the well-being of any business. Whilst it is probably true that patients may be persuaded to register with general practitioners for the same reason they choose to use any other provider — an attractive shop-front, a good reputation and a friendly attitude by staff — once they have chosen a doctor few change unless they move, even when dissatisfied with the service offered.

The empirical argument about the benefits and disadvantages of the small business model of general practice, and what the consequences of various changes to the structures under which it operates would be, must be distinguished from evaluative views on the desirability of a consumer-business relationship in general practice, or how various balances should be struck between business and moral models to achieve the goals we seek. This distinction is particularly hard to make in considering these issues, since such changes are seen as a political matter to be decided by argument rather than the analysis of data. The empirical consequences of legislation are hard to assess, and cannot easily be subjected to scientific experiment. Even when empirical evidence is available, this is frequently used selectively to support evaluative political positions rather than in a dispassionate search for truth.

Evaluative aspects of the business model

The view of general practice as a business has the advantage that it recognizes an aspect of reality which moral models often ignore. General practitioners, like other human beings, have practical and emotional needs. They need to eat and pay the bills, have time off, holidays, and so forth as other people do. Ignoring these needs creates a false impression of what it is reasonable to expect of even the highest quality general practice. Personal needs can conflict with the needs of the patient at times. We must consider how these conflicts can be resolved. This is an evaluative issue which depends on our views on responsibility, justice and individual rights and duties.

We have seen how different models of general practice lead practitioners to emphasize different aspects of their work, producing different types as well as qualities of care. There are also various views of what is best in total amount of work. Hours of work in professions are not fixed. The open-ended possibilities of general practice mean that doctors have to make ethical decisions about their time off. Do they do their own on-call, use a deputizing service or share with a colleague? Do they see patients on Saturdays? Do they let a patient go on pouring his heart out at the end of surgery or shut him up and get home to dinner? The independent contractor status means that doctors are continually making ethical decisions about patient care which affect their take-home pay and personal life. Does the good general practitioner work without limit for her patient's good, or is this a gullible giving way to exploitation, which promotes undesirable dependency and unreasonable behaviour from one's patients? Is there a golden mean between workaholism and shirking?

The notion of general practice as a business raises other problems which relate to our fundamental values. The free-market philosophy includes the empirical belief that the market is the most efficient way to ensure a high quality product. The possibility of exploitation of customers is believed to be controlled by the action of market forces, or as a second-best by appropriate regulatory mechanisms. These problems are seen as a necessary price for the benefits of the market system. This is of course an evaluative judgement. Most would agree that this system of providing general practice has served Britain well (GMSC, 1984), particularly when compared with the demoralized State-run primary care in the former Warsaw Pact countries. However, this does not mean that we have the best of all possible systems, and that a better trade-off between benefits and disadvantages for doctors and/or patients could not be achieved by a different set of regulations, or even a totally different system. It is no longer heresy to discuss a salaried general practitioner service, even in the GMSC (1992).

This is not the place to conduct this debate, which is, however, an important one. What must be borne in mind is that this is both an empirical and an evaluative question, which must be debated using the methods appropriate to each aspect.

The dual role, as altruistic professional and as business manager, does give rise to moral conflicts for the doctor. The primary goal of the business person is profit. High quality service may be essential for long-term success but it is a means to an end not an end in itself. There are businesses which for lack of competition, consumer choice, or ability to discriminate continue to make good profits despite offering poor service. Monopolies and cartels can, like professions, be "conspiracies against the laity" (Shaw, 1911).

For the moral philosopher the business model raises the Kantian problem discussed before that people can be seen as means and not as ends. This abstract philosophical question has practical implications. There is a prevalent view that moral principles do not apply in business, or at least that a different and more competitive code operates. The aim is to push as hard as possible against the limits of law and ethics if it is profitable to do so. "Business is business, and there is no room for sentiment." How does this relate to good general practice? Does the business motivation conflict, psychologically or administratively, with the orientation to benefit the patient? What sort of business integrity do we need in general practice?

An example of this sort of conflict is the question of the removal of patients from a doctor's list or refusal to accept them for financial reasons. Some patients are bad financial risks. They consume a lot of time, or threaten income, for example by refusing to have smears so that the doctor fails to achieve a target payment. It is not hard to predict such bad risk patients. In a business world to refuse or remove such patients whenever possible is common sense. Insurance companies do this when they refuse bad risks for life assurance. However, such action by general practitioners has been widely criticized (Sefton, 1992).

We have to balance the doctor's need for an income and the benefits in efficiency which arise from the small business organization against the encouragement of practices which we consider undesirable, and decide according to our values. It is not, however, logical to pay doctors to behave like captains of industry and then expect them to behave like platonic gentlemen.

Patients as consumers

The other side of the coin to seeing general practice as a business is to see patients as consumers. If patients are customers then the customer is always right. After all, medical practice exists to benefit the patient rather than the doctor. Should not patients decide what they want out of general practice, rather than doctors decide for them? In this view the doctor provides a service which the patient pays for. Health care is a service commodity like restaurant meals or hotel accommodation. Not surprisingly this concept has taken root quickly in the USA. There money often changes hands directly between doctor and patient, so the resemblance to other services is much stronger.

The patients' rights movement can be seen as part of a wider movement to re-establish the power of the consumer against business providers who, by taking little notice of what people wanted, manipulating them by high-powered advertising campaigns or by restricting choice, led people to expect only what businesses wished to provide. Although in a sense it demeans it, because the issue is much more important, the movement for patients to be heard in health care has much in common with the Campaign for Real Ale, *Which?* magazine, and the efforts of Ofgas to get sense and service out of British Gas.

Consumerism has been one motive for the rise in concern for patient autonomy in discussions on medical ethical issues. One does not have to accept the whole package of consumerism to believe that patients should have more choice and power in decisions about health and the health service, and particularly about their own health care. There are other philosophies of which such views are a natural part. The consumerist view, however, raises some important evaluative issues.

Consumerism has had little impact so far on the core activity of general practice, perhaps because the matters which most affect this are hidden behind the consulting room door, away from public gaze and largely hidden even from fellow professionals. This makes it hard to evaluate and to criticize. Even when the Government introduced reforms to encourage consumer choice in 1990 it could only address administrative details peripheral to quality of care, such as ease of changing doctor and the provision of factual evidence about practices.

Apart from the private nature of general practice, there is as with any specialist service the problem of ignorance amongst users, which inhibits the operation of market forces. Consumers are not in a position to assess the quality of the product, or even whether they need it at all. In Chapter 4 the analogy was drawn between the biomechanical model and a car mechanic. This analogy also applies to the customer-business relationship between doctors and patients. If a mechanic or a doctor says a repair or a treatment is necessary, the lay person does not have the knowledge to argue. Few people can assess the professional proficiency of the provider in either case. Therefore the customer is forced to judge on the basis of peripherals: for example, whether the organization is smart and efficient, or whether the staff are friendly. These may or may not correlate with technical ability. This is an empirical problem with a consumerist critique of general practice.

An important evaluative issue is the implication that the customer is always right. The first duty of the doctor in a

consumerist model is not to mend the patient's broken body-machine, to help her understand her illness or to keep her healthy, but to keep her happy. At first sight this seems an unexceptionable proposition to which no reasonable person who believed in patient autonomy could object. On closer examination, however, there are problems with it.

For example, general practitioners are commonly approached by people not known to them who request drugs of addiction, often on some improbable pretext. In a fully consumerist world the doctor would have to accede to this request. However, many would feel that if the doctor believed the drugs would be abused she should refuse them, or prescribe only as much as might be reasonable for usual purposes. A doctor who did not do this, but responded according to a consumerist model, would be considered a bad doctor by colleagues and by the general public outside the subculture of addictive drug use. Society does at present take this view. In extreme cases this is one reason for a doctor being removed from the medical list. For those who believe that the free availability of addictive drugs is a social evil, total consumerism would therefore pose a problem. This example implies at least some limits to consumerism.

More generally, general practitioners are often asked for something which in their view is not for the best. Patients with back pain commonly ask for an x-ray believing that this will shed light on the situation. In fact it is rarely any help. Do we want a consumerism where the doctor accedes to such requests, or a service where the doctor advises the patient and they negotiate a decision? Many, including some patient 'consumer' representatives, would prefer the latter. The consumer looks, and directly or indirectly pays, for an expert opinion. If a shopping analogy is appropriate, it is the specialist shopkeeper who advises his customers on sound purchases within a narrow range of goods, which is the parallel, not the 'pile them high and sell them cheap' self-service hypermarket.

Another implication of consumerism is that health care is a commodity. In capitalism the more commodities you have the better. Liberal economic theorists believe that if you want to maximize the quantity of goods available then the free market is the best way to do that. For doctors the more health care you sell the better, and for patients as consumers the more you can purchase the better. This interpretation is, of course, based on a category mistake between means and ends. People, except perhaps for a few exhibiting Munchhausen syndrome, value health care not as an end in itself but as a means to an end, that is health. Thus it is health however we choose to define it which we seek to maximize, not health care. Indeed many would argue that the less health care we have for a given level of health the better. This is a further limitation to applying a business model to health care.

Consumerism is a rationalist model. The rational consumer makes a free and informed choice amongst the goods on offer. It is again an impersonal choice. It does not really matter whether I get my health care from Sainsbury's or Safeway. It is value for money and reliability of the product which matters. The difficulties with rationalist and impersonal models with respect to some views of good general practice, as discussed in previous chapters, therefore apply also to consumerism.

Not a model of good general practice

A business/consumer model does not provide an aim for the clinical content of general practice. It defines who makes the choice but not what that choice should be. It is a model of the doctor-patient relationship, not of general practice. The individual consumer or the corporate body still has to make decisions on the nature of the good and the proper concern of general practice. The models of care described in the last three chapters would be pre-eminent amongst the choices on offer. Thus patients or patient groups are faced with the moral choices already discussed. A moral decision is required by doctor or patient or in collaboration. This will depend on values and all the other philosophical issues we have already discussed.

Doctors appear to be freed by consumerism from making ethical choices. In a free market they just put their wares on display as it were, and wait for the customers. If the customers come, they flourish; if not, they take up another occupation. In a consumerist version of the anticipatory care model, they do what the Government or the workers' commune tells them to. Even, however, if we accept an extreme consumerist model, the doctor cannot escape a degree of moral responsibility. This responsibility is no different from that of the ironmonger who (before the present legal regulations) sold glue suspecting that his customers were planning to misuse it. He had to decide whether to let the customer have free rein, or to try to limit sales to consumers requiring its physical rather than its mind-altering properties.

Similarly doctors have a moral responsibility for what they offer, even if patients as individuals or as a society have to make the hardest choices. Doctors must decide what is best to offer and reconcile that view with the customer's demands. If what the customer wants is not what the doctor feels would be best, she must decide whether it is acceptable to meet the patient's wants or morally necessary to refuse to do so. Since in its most extreme form consumerism seems untenable, any concept of the doctor-patient relationship we are likely to hold will put more than this minimal moral responsibility on the doctor.

The tension between the altruistic and the business models of general practice does, however, highlight other philosophical issues which we need to clarify in order to build a coherent model of good general practice. These are a theory of justice which enable the doctor to act fairly to her patients, her staff and herself, and a satisfactory view of the basis of the doctor-patient relationship.

CHAPTER 8

The doctor, the patient and the family

A TRADITIONAL name for the general practitioner is the family doctor. Marinker (1976) has pointed out that it is only since the National Health Service began in 1948 that all members of a family have been insured for medical services in the same way. Previously there were different arrangements for wage-earners and dependants, and a mosaic of services such as local authority clinics and charitable hospitals supplementing private and insurance-based general practice. Although often different family members were cared for by the same doctor, even if he were paid in different ways, Marinker may be correct that it is an historical myth that care in family groups has been the norm. Huygen (1978) is also probably correct that with increasing population mobility caring for a stable family of several generations over a long period, which he describes in such detail, is becoming increasingly rare, although it certainly still occurs even in inner city practices with very high population mobility such as my own.

Whatever the empirical reality of family relationships with individual doctors, in the UK today we are more prone to speak of general practice or primary medical care than of family medicine. In contrast in North America general practice almost disappeared under the pressure of high technology specialist medicine and the Moran (1958) view of quality. Without a referral structure which in Britain protected them even at the nadir, and without a universal State payment structure, general practitioners had to sell themselves vigorously to survive. What we know as general practice has therefore taken on a new lease of life as family medicine, and the term family practice is used in preference to general practice. Thus the postgraduate qualifying boards and faculties have the title of family medicine, not general practice, and journals similarly include the term in preference to general practice.

Family practice is part of the American general practitioner's fight back. In order to convince the general public and themselves that they had something to offer, they had to find something special which no-one else had. We have seen how some British general practitioners found this in Balint and later in anticipatory care. Even though the structures made this less necessary for the continuance of the discipline, these concepts helped general practice to gain self-esteem and to develop. In North America a parallel stimulus seems to have been found in family therapy and systems theory.

It is interesting that Huygen (1978) too was led to his major contribution to our understanding of the relationship between health, illness and the family for political reasons — in his case the need to find a subject to lecture on which did not tread on any of his colleagues' toes. This does not negate the importance of his empirical findings but it needs to be borne in mind when evaluating the philosophy on which he based them.

Some argue that family medicine is nothing more than a marketing exercise, designed to appeal to the conservative intuitions of middle-class middle America, cashing in on the axiomatic goodness of family life in North American society. In this view the concept of family practice does not mark a new age with a new conceptual framework: it is merely an old lady in a new frock. As a social theory this may have some truth. However it does not necessarily follow that the concept has no intrinsic merit. Perhaps the struggle has led North Americans to a clearer understanding of the nature of general practice, which has not happened in Britain where it has been protected by institutional defences. We need to consider whether family practice is a specific model of general practice. If it is, we must study its specific characteristics, whether they are empirical or evaluative, and what concept of good practice they imply.

What is the family?

The main problem with the concept of family practice is understanding what it means. Both the concept of the family and the essence of family medicine are elusive. A definition of the family is clearly vital if we are to say anything about their care. It could mean:

1. *The 'nuclear family' of mother, father and one or more children living at home*

Although these units are important in society, it is a matter of demographic fact that in Britain, as in most Western societies, only a minority of people are part of such families at any one time. This is almost inevitably so, since of an average 75-year life span only about half is likely to be spent caring for or being a dependent child. The situations of those at other stages of their lives vary widely. Single people living alone, couples married and unmarried without children, and groups of friends sharing accommodation are common at other stages of life. Also there are other units of living in a pluralistic society such as single parenthood, same-sex couples, and the extended family networks common in many cultural groups.

2. *The extended family including more distant relatives*

These units are sometimes important in health, providing support, imposing stress and burdens, and in the case of ancestors providing part of the genetic inheritance and a cultural basis of axioms and health beliefs. However, they fre-

quently live apart and therefore are often not cared for by the same family doctor.

3. *People related by blood or marriage who live at the same address*

This group includes nuclear families and other common units, for example elderly couples, young childless couples, widows and widowers with children, and single parents with children. But what about live-in lovers of the same or opposite sexes? Are these families or "pretended family relationships" (the term used in Section 28 of the Local Government Act 1988 to describe homosexual relationships seen as an acceptable alternative lifestyle to heterosexual family life)? If they are included, then the definition being used is different. If they are excluded, how should they be dealt with?

4. *People who live together at the same address*

This is Huygen's definition and has the merit of being definable operationally. The 1991 census, for example, used a definition of 'household' as people sharing accommodation and eating together at least once a week. It includes all the above and any we have not thought of. Even with such a pragmatic definition the boundaries are grey, and different variables we are interested in may not correlate. Eating together is a straightforward, measurable variable, but its wider significance is not clear; one active family may rarely eat together yet be a tight network of caring relationships, whilst another may share every meal in bored indifference.

It is practically useful for doctors to care for all the people who live in one home. Doctors get to know everyone so that when A is sick he knows B is around to be worried and take care of him. If several people who live together are ill then it avoids several different doctors being called. But does it provide a uniquely important basis for medical care? If A does not live with C but cares deeply about her, then the doctor may not know of this concern or even of C's existence. C may be abroad. What then is the doctor's relationship to her?

5. *Those who are concerned about the patient and involved in his care whatever the legal or blood relationships*

This may be important to know in many situations such as the patient who needs practical help during an illness; but how can the rights and duties of such individuals be defined, and what level of concern is necessary to qualify as family in this sense?

6. *People defined as such by the patient*

People can choose who is their next of kin. Can they define their own family? Whilst people mostly do not do so overtly to the doctor, they may be seen as doing so implicitly when they make statements such as "tell Maisie"; "don't let Bert know". Is this defining the limits of a family or merely setting or modifying pre-existing limits of family rights?

Different ideas of the family will affect our practice whatever our view of family medicine. General practitioners have a number of transactions with family members and other relatives or friends of the defined patient. These include giving information about the patient to those who have a concern and on any basis a 'right to know', collecting information about a patient, and arranging care for a patient. They may choose to offer care and comfort to family members other than the 'designated patient' in cases of illness. For example, they may deal with relatives' anxieties about the patient's illness. They may see a problem in one 'patient' as a symptom of a problem with another person in the family (Balint, 1957; p.35). They may take into account the interests of one person when treating another (Christie and Hoffmaster, 1986), for example trying to protect a relative from catching a sexually transmitted disease, or suffering from the stress of being a carer as a consequence of the patient's illness.

The decisions the general practitioner makes in such situations will depend on her concept of relationships, both family and non-family, and the rights and duties which these give rise to. Do they arise simply as a result of blood relationship, or do they need to be explicitly defined? Are there things which can be taken for granted in a marriage as an automatic consequence of that relationship? How do we decide about those in less conventional relationships?

Although the law provides answers to some of these questions in certain situations, there are many cases where there is no legal guidance. Even where this exists it is always necessary to ask whether what the law requires us to do is morally right.

The definition of who is the patient for family practitioners depends also on our understanding of the basis of the doctor-patient relationship, discussed in the last chapter. Does the doctor owe a duty to anyone in need, or only to those with whom an explicit contract has been made? This will affect the situation of non-patient family members. Is a covenant made with an individual or a family? Such questions must be addressed in order to decide what is the best practice in dealing with families.

What is a family doctor?

The fullest discussion of the meaning of family medicine and an analysis of its moral implications is to be found in Christie and Hoffmaster (1986). Writing from within the culture of North America they find it hard to pin down exactly what is meant by the term, suggesting that our difficulties are not merely cross-cultural.

They distinguish five interpretations of a family practitioner, ranked according to the 'strength' of the concept. The lowest level is that family practitioners will and can treat all the members of a family. To someone accustomed to unified primary medical care open to all this seems hardly worth saying. In the USA, however, primary and secondary care are fused (or confused), and patients often receive their primary medical care from an array of specialists. Therefore individuals have several different doctors, whilst adults and children in the same family see different specialists, parents seeing internists and their children seeing paediatricians. Russia has a very different type of organization, but there too children and adults see different doctors who are trained separately from an early stage and most care is given by a variety of specialists. Family practice in the most basic sense, therefore, does not exist in all countries. It is a specific choice and not an inevitable type of medical care.

This arrangement, however, is implicit in the way our ser-

vice is organized. Almost all British general practitioners care for at least some families however tightly the term is defined, since commonly if not invariably members of a family will share the same doctor. This implies nothing else about such practitioners. They may work according to any or all of the models already described, or any others. The advantages are convenience to patients and the doctor's greater understanding of a patient which comes from knowing other significant people in his or her life. The disadvantage lies in the potential conflicts of duty between the doctor's relationships to different patients. These are largely empirical matters, although how we balance these pros and cons will depend in part on how much importance we place on individual autonomy, confidentiality and our need to respect these.

The second level defined by Christie and Hoffmaster (1986) is that the patient's health and illness should be understood in the context of their family relationships. This seems close to Balint, who with his psychoanalytic background sees family relationships as the most important, although not the only cause of psychic conflict which manifests as illness. Professor Malvin Salkind (personal communication) has suggested that the reason that concepts of family medicine have never really excited much interest in this country was because we have Balint instead, filling that 'ecological niche'.

There is, however, a strand of this type of thinking in British general practice. For example, Tomson (1991) is a well known proponent of the importance of the family for UK general practitioners. He argues that better understanding of the individual's problems can be gained from exploring the family tree with them. Patterns of health and behaviour, genetic and learnt, can be seen repeating in different generations. The cycle of deprivation described in social work is well known to general practitioners. A child raised in surroundings which are both physically and emotionally poor, who has low levels of education and expectations, grows up ill-equipped to provide any better start in life to his or her own offspring.

This notion of family medicine differs from the biomechanical model, since it involves seeing the illness not merely as a physical dysfunction but in "physical, psychological and social terms" (RCGP, 1972). Unlike hermeneutic models, however, it does not necessarily imply a shift of emphasis from modifying disease to understanding it, although it is not incompatible with this. Anticipatory care is conceived mainly in individual terms because of its biomechanical roots, but consideration of the importance of the family is not incompatible with the model. In practice, however, because of the emphasis on measurable and physical factors, wider social forces such as work, housing, and the physical environment are at least as important for this model. The family acts largely through genetic factors (which although important cannot easily be modified) and through psychosocial influences which are hard to quantify.

Christie and Hoffmaster's third level is that the family physician is willing and able to use family therapy "when indicated". They reject this notion as empirically false since not all family practitioners use family therapy and those who do so vary in the situations where they use it; and they may do so themselves or refer the family to another therapist. Certainly this is true of British general practice, where family therapy is the exception rather than the rule.

Whilst their grounds for rejecting the concept seem to confuse what most people do with what is right, their view that family therapy does not form the basis for a coherent model seems sound. Quite what is meant by "when it is indicated" is unclear, as this involves judgements about the relationship between family dynamics and illness. However, family therapy is largely a technique for dealing with psychological and psychogenic problems, and few people would be idealist enough to argue that all general practice can be subsumed under those headings. Even the most enthusiastic family therapist would concede that this is not the treatment of choice in many situations. In any case it is hard to see how a model of any sort of medical care could be based on the use of a single therapeutic technique. It is akin to defining cardiology as the specialty of doctors who do angioplasty "when it is indicated", or who use ECGs in making their diagnoses. This difficulty is particularly great in a field such as general practice where a wide variety of problems necessitates a correspondingly wide range of techniques to deal with them.

The fourth interpretation is that family practice implies commitment to the family unit "as a whole" as well as to individual members. The fifth level goes beyond this commitment to real families, to a commitment to "the idea of the family", and to "strive to preserve, foster and promote the integrity of the family in society."

Both of these are rejected by Christie and Hoffmaster (1986). They argue that it makes no metaphysical sense to postulate a responsibility or a commitment to an abstract concept such as the family separate from one's commitment to its individual parts. Furthermore they believe that to attempt to do so would imply the subordination of the individual person to an abstract concept. In Kantian terms it would be to treat them as means and not as ends.

Both these models require an evaluative view of good family life. No-one could seriously postulate a commitment to the continuance as it is of a family characterized by violence, hatred and child abuse. Either we must will that the family break up and the members find a more satisfactory mode of living, or we must have a vision of how the family might improve. Unless we are prepared to encourage or help such a development then it is hard to see what a commitment to the family means. Thus even a commitment to the family "as it exists" involves an evaluative vision of the good for an unhappy family.

The family is a sentimental fiction?

A further criticism of the fifth level, commitment to the idea of the family, is that it does not smuggle social values in under its cloak, as our other models do, but imports them with the discretion of a removal man carrying a grand piano. This undisguised commitment to social engineering has led some people to criticize family medicine as dangerous to good patient care. Thus Marinker (1976) made a scathing attack on it as "a mish-mash of vague sentimental yearnings, mythologies and traditions about family life" without any sound moral or factual basis.

Although his ideas (first put forward as a public address) are characterized by rhetoric rather than clear argument, some of his points are sound. He points out that there is in fact no long-standing tradition of family doctoring, and pre-

sents data illustrating that at the time of his address it was common for families not to be under the care of one general practitioner, or for at least some family members to be missing. Although these empirical points put the discussion into context, they are of no moral relevance to whether we should be caring for families, and if so how.

More evaluatively important is his criticism of the family as a social/political myth. He refers to it as an "icon". There is no shortage of references, particularly from right-wing politicians and conservative religious spokesmen, to the family as a desirable social institution. He quotes Leach's reference (1967) to the family as "an emotional gas-chamber" in an attempt to counterbalance the sentimentality to which such views are prone to lead.

Vague and ill thought out arguments in favour of family practice are certainly common. Christie and Hoffmaster (1986), despite rejecting the strongest concepts of family practice, are not immune to this. They argue that the family is more important in the genesis and effects of illness than work, whilst also stating that the relationship of events in the workplace and health has not been as well established as between events in the family and health. Leaving aside the questionable empirical truth of the latter statement, this argument is illogical. If the relationship between work and health has not been adequately studied then one cannot say that its effects on health are less than those of the family. Their view seems to rest on an evaluative belief that the family is "the centre of most people's lives, the unit of living". This may be true for most people, but such statements need critical evaluation and either factual data to support them if proposed as empirical judgements, or philosophical argument if they are evaluative statements.

It seems that Marinker may be correct in saying that much of what is said about family medicine is sentimental and ill thought out. His warning is important, and not invalidated by his excessive rhetoric or his misquotation of Tolstoy in support of his case.[7] We must be aware and critical of such emotive forces. There is otherwise the risk that general practice will incorporate prevalent social values uncritically and unconsciously, and be led to conclusions which we would not deliberately choose.

The family and good practice

If there is no clear meaning of family practice it is not a model of good general practice which can stand as an alternative alongside the others we have discussed. There are however important issues about good practice raised by the idea of the family doctor. It reveals how our view of what it is best for general practitioners to do is affected by our view of the family and the basis of personal relationships. People are not ill in isolation, and individual models of personhood which exclude relationships and the physical and social environment are inadequate. Perhaps much of the attraction of the idea of family practice lies in the hope that it will overcome these inadequacies. Without more sophisticated philosophical concepts than are presently in use, however, it is more likely to lead to an orgy of woolliness.

Arguments for or against family practice are again beset by the now familiar confusion between empirical and evaluative judgements. There are three issues. The first is whether there are practical measurable benefits in a system whereby one doctor cares for an entire family.

This is a empirical argument. The family's shared doctor knows about an important element in each patient's life which will affect the development of illness and its social implications, as Huygen (1978) clearly demonstrated. Doctors may gain useful information from one family member which may help in caring for another. This contributes to understanding and therefore to better medicine. Members of the same family are often ill together, for microbiological and psychosocial reasons, and it is convenient both for doctor and patient if these problems are dealt with at once. It seems foolish for two doctors to visit two patients ill at the same time in the same bed! Beliefs about health and illness, and about the use of health services are cultural beliefs, "memes" (Dawkins, 1976), which are commonly transmitted through families. The family is, however, only one element in such a cultural system. Perhaps Fuller's model of the individual at the centre of concentric circles of family, social network and wider cultural influences (Fuller and Toon, 1988) more accurately reflects reality than an emphasis solely on the family unit.

Work such as that of Huygen (1978) has demonstrated that the family is an important field for empirical research on the social context of illness, and that such research adds much to our understanding of illness. Whilst this is an important empirical point, it is no different in evaluative terms from the view that illness should be seen in "physical, psychological and social terms" and not merely as a biological dysfunction. There seem to be no grounds for singling out the family as different in type from other social factors, even if it is usually the most important.

Similar arguments could be made for general practitioners to focus on wider local communities, and many practitioners do try to keep their practice geographically compact. Tudor Hart's arguments (1988) about community care support such a neighbourhood rather than family focus. The boundaries of such units would be no less vague than that of the family. Except in remote areas communities have no clear boundaries and social networks spread outside geographical limits as much as outside families.

A case could also be made for basing primary care around workplaces, where many people spend more waking time than with their family. Whilst in illness we often stop going to work, and relationships in families are often, but not always, more intense than those at work, there are factors on the other side. The workplace-based doctor might be more convenient for many people, and would have a greater understanding of occupational factors in health. Much of the preference we have for people having a general practitioner based near home rather than work probably has more to do with convenience for the general practitioner when home visiting than any emphasis on the importance of the family. In societies such as New Zealand, where home visits are uncommon and out-of-hours care arranged separately, a general practitioner convenient for the workplace is more com-

[7]He says: "If Tolstoy is correct that all families are unhappy in their own way..." What Tolstoy in fact wrote is usually translated as: "All happy families resemble one another; each unhappy family is unhappy in its own way." (The famous saying is the first sentence of *Anna Karenina.*) Tolstoy makes no judgement here as to whether most families are happy or unhappy, but merely postulates something about happiness and unhappiness.

mon. If as seems likely our out-of-hours arrangements change, we too may see a significant change in this respect.

The evaluative issues

The first evaluative issue is the definition of the responsibility of doctors to members of a family (whatever the term means) who have not declared themselves as patients. This depends on our understanding of the basis of the doctor-patient relationship. Moral uncertainty about duty to different individuals may be easier to deal with if all are overtly defined as patients. This may be seen as an advantage of family medicine, although the problems raised by conflicts of interest between different members of a family may cancel it out.

If one accepts a beneficence model in which doctors should help anyone who needs and can benefit from their services, then the responsibility to a family member who is not a patient does not differ from that to a patient. In such a model, definition as a patient carries no special weight. If one accepts a contractual or covenant model, the duty to a non-patient family member depends on whether one believes that rights arise in relatives as a consequence of their relationships, and if so what relationships are involved and how these rights arise. There are innumerable possibilities depending on both the various definitions of the family described above and on different theories of the origin of rights.

In any such model responsibilities to members of the family who are and are not patients may differ. Responsibilities to a patient will be those specifically created by the doctor-patient relationship, plus those due to any human being by the doctor both as a doctor and as another human being, plus any which arise from the patient's family relationship to another patient. The responsibilities of the doctor to a non-patient will include the last two but exclude the first.

There is a wide choice of options, and much work to be done to decide what it is right to do. In order to define good care in such situations we need to ascertain what rights relatives have and which relatives have them. Such rights may arise from the relationship itself, or they may be 'earned'. We need a philosophy of the family which provides a rationale for such decisions. Our lack of such a philosophy explains why we so often find decisions in this area difficult.

The second issue which the concept of family medicine raises is the relationship between our responsibilities to do good to the individual and our responsibilities, if any, to benefit groups such as the family, however defined. This is similar to the tension between benefit to the individual and benefit to the community discussed in Chapter 6, except that we are now considering small, particular groups rather than anonymous populations. Just as in part our view on anticipatory care will depend on our political philosophy, our view on family practice will depend in part on our philosophy of the family and of personal relationships. Should the family be treated differently from other aspects of the individual's background such as work and other personal relationships?

Medicine has traditionally been based on caring for individuals. We need to be more precise about what it means to say that the family is the 'unit of care'. A possible implication of any concept which moves away from the individual doctor-patient relationship is a move away from treatment directed at the individual as an autonomous being. In Kantian terms there is the possibility that treating the family, or other members of the family through the patient, may lead to the patient being seen as a means rather than an end, in the same way as the good of society can easily be sought above the good for the individual in the anticipatory care model. This is perhaps what Marinker (1976) means when he says that to see the whole family as patients can lead to a "collusion of anonymity". Can clinical medicine exist apart from its individual Hippocratic basis? In trying to treat the whole family may one end up unclear about what it is right to do for anyone? We need to add these issues to our philosophical agenda for developing a clear view of good general practice.

CHAPTER 9

What therefore *is* good general practice?

HAVING analysed the models and philosophical concepts underlying general practice, it is now a little clearer what it means to ask "What is good general practice?", even if the answer is more complex than might have been expected. In this chapter we will review what we have learnt about the different concepts of good general practice and the philosophical differences between them, and consider their practical implications. Finally we will consider how the various models of general practice may fit together and the tensions be resolved.

There is not one but several meanings of good general practice. First there is the ambiguity of the word 'good', meaning both effective as a means to achieve an end, and an end which is desirable. The problem of defining effective general practice is a matter of scientific judgement, which must be distinguished from defining that which is worth striving for. Most work on quality of care has addressed the former and ignored the latter question, or confused the two issues. If we wish to be clear about what good general practice is, we have to consider more carefully our understanding of the evaluative meaning of 'good'.

Two views of the purpose of general practice

Values are complex, and the exposition of the values of the different models in the discussion above is only superficial. It is clear, however, that there are two fundamentally different views of the purpose of general practice, and the tension between the two is central. One is that the goal is to adjust the patient's reality to meet an image of health as long life and absence of disease. This view one can refer to as hedonic, since the goal is the pursuit of pleasure and the avoidance of pain. The other is that of helping individuals to understand and hence to adjust to the illnesses and problems to which they are subject. This might be called hermeneutic, since in this view medicine is concerned primarily with the patient's search for meaning.

These two aims reflect different views of the meaning of health. They do not arise in a philosophical vacuum but are the application to the problem of health and illness of more general views on the purpose of life, or of the nature of the 'good life'.

The hedonic view, exemplified by the utilitarianism of Bentham (1983), is that the good life is "a long life and a merry one". For him happiness in the sense of enjoyment or pleasure was the ultimate good, and the moral value of actions was judged by the degree to which they promoted "the greatest happiness of the greatest number". If one accepts this view then the role of medicine is to postpone death, and any interference with enjoyment of life, as much and for as long as possible. By removing suffering and prolonging life people are free to do with life what they will. This is the model underlying the biomechanical and anticipatory care models.

The other view sees life as having a purpose beyond getting the most enjoyment out of it. It is seen as a process of growth, development, and exploration with a goal or end. Such theories are therefore referred to as teleological. The good life involves 'making the most' of this process. The seeking of pleasure and the avoidance of pain may be desirable, all other things being equal, in some but not all teleological models. They are not, however, seen as the be-all and end-all of life, and all other things are frequently not equal.

The role of medicine is to facilitate our teleological purpose in one area of life. Proponents of this view often make much of the etymological link between health, healing, wholeness and holiness. This is the view of the 'Growth' psychotherapies (which these days include not just humanist psychologists such as Rogers, Kelly and psychoanalysts but also scientific cognitive behaviourists, the more thoughtful heirs to the Skinnerians). In philosophy obvious proponents of this view are Aristotle and Aquinas. Balint is the standard-bearer for this view amongst the models discussed above, but other teleological/hermeneutic models also hold this value.

This second view is perhaps more prominent in general practice than in hospital medicine because of its long-term relationships, and the chronic and intractable nature of the problems which are seen; hospital medicine, especially the acute specialties, fits better with the "if it offend thee, cut it out" approach of the first view.

Different meanings of good general practice

Since the models described above differ both in their empirical scientific judgements, and more importantly in their underlying value structure, they will naturally lead to different concepts of good general practice. According to the biomechanical model good general practice is characterized by technical expertise in the diagnosis and treatment of the diseases which the patient presents. According to teleological/hermeneutic models such as Balint good general practice is characterized by the quality of the relationship between doctor and patient, and the growth in understanding and humanity which the patient gains from this relationship. In the anticipatory care model, good practice means structures for screening and health education, reaching a large proportion of the population and ultimately reducing the incidence of disease. In the business/consumerist view, the

good practice is efficient and profitable, and provides the services which patients want.

We can therefore see why there is so much dispute and uncertainty about what we should be doing. Although a great deal of uncertainty is due to the inherent complexity of empirical medical decision making (*ars longa vita brevis*), much of the difficulty arises from philosophical not scientific confusion.

Practical implications of these differences

The question as initially phrased is therefore at present unanswerable. We cannot define good general practice in a unitary way and rank practices according to how close they come to an ideal. This is not just because of the difficulty of measuring some of the variables involved, although that is indeed formidable, but because our concept of the good is not unitary. The basic assumptions of the models differ. Therefore it will require a great deal of philosophical progress to make them coherent.

This has important implications for Government, for the Royal College of General Practitioners, and for vocational training. All these institutions will promote confusion and futility if they encourage or require people to attempt what is logically or practically impossible. This state of philosophical anomie is a major contributor to low morale amongst general practitioners, and perhaps helps to explain why the College is not held in universal high esteem. General practitioners are being asked to do things which are mutually incompatible, since they arise from different models of the good, or are being coerced into a model of the good incompatible with their basic beliefs. Since concepts of the good are central to our psychological structure and personal identity, strains upon these or threats to them provoke profound distress (Kelly, 1955).

There is a particular problem for summative assessment, whether as an end-point assessment for general practitioner trainees, in any reaccreditation scheme which might be introduced, and of course for the MRCGP examination. Without an agreed concept of good practice there can be no consensus on what is a valid assessment. Validity implies that the method measures what we think we are measuring, which in turn requires us to know what this is. No matter how well organized and reliable our assessment techniques and how good our sampling methods, they cannot be valid unless we are clear about our goals. Few assessment schemes have had the courage to grasp this nettle.

The conflict which arises between models are not only of importance for politicians and academics seeking to frame regulations or plan education and assessment programmes. Both doctors and patients bring these models to the consultation, either as a permanent philosophy or for this one occasion. Problems do not arise merely from the fact that doctors use different models; patients do too. Some believe that if anything feels wrong they should go to the doctor, who will mend it (biomechanical patients). Others want to know why things are going wrong with their body or mind (teleological/hermeneutic patients). Yet others want the doctor to help them to stay fit (anticipatory care patients), or to do what they want her to (consumerist patients).

It is often hard for doctors to work out which model the patient is using, particularly if the patient is not known to the doctor, or does not always use the same model. If the patient uses one model and the doctor another their conversation will be what in philosophy is referred to as incommensurable: they are using different frameworks which do not connect, as if they were speaking different languages, or using different systems of measurement, like trying to add up pounds and kilos. They will talk past each other, not to each other. Neither will be satisfied with the outcome of the contact (Fuller and Toon, 1988; ch.2).

Balint (1957) points out that often doctors convert patients to their model, or select patients who already accept it, which he refers to as "the apostolic function". Of course doctors may also be persuaded to change to the patient's model, although the power difference in the relationship means that this is less likely to happen.

Both doctors and patients may experience confusion as to which model is appropriate in a particular situation. Some of the difficulties of the cases in Chapter 1 can be seen as involving confusion over which model to prefer. Thus the difficulty for the doctor in Case 1 is largely due to uncertainty as to whether to act as a biomechanical doctor or as a teleological doctor. Case 2, on the other hand, is in part a conflict between being a biomechanical reactive doctor and an anticipatory care doctor.

Disagreements are most often due to the different values associated with the models. For example, consider the interminable debate on the best way to provide out-of-hours care. There is room for differences of opinion on empirical matters, such as how much time is saved by knowing the patient, and how often access to the notes and the opportunity for the same doctor to follow up the patient affect quality of care. The main reason, however, for the debate and for the heat it generates is that it is primarily a matter of differences on fundamental philosophical issues. To what extent is general practice a skill exercised impersonally, like mending a machine, and to what extent does it depend on highly personal relationships?

A practical interim solution

Where do we go from here? To suggest a free-for-all with no concept of quality at all seems too much a counsel of despair. That there are alternative definitions of good general practice does not imply that there is not good general practice. We are faced with the need to choose between different goods rather than between good and bad. Nor does the difficulty of the problem mean that it can be ignored or abandoned. Although there are conflicting concepts of the good, there are also conceivable (and alas discoverable) examples of general practice which are an unacceptable distance from any of them.

Since there are various views of what general practice should be and different types of excellence according to those views, probably the most practical way to conceive of quality is as a multidimensional concept in which excellence on one dimension is in some degree incompatible with excellence on others.

Because of the practical and logical conflicts between goods arising from different models, the best we can hope to do in the immediate future is to produce a 'profile' of a practice describing its excellence in different areas. The goals linked to the different models may provide a starting point

for such a multidimensional rating. Excellence in diagnosing and treating established illness, in preventing the onset of illness, in enabling patients to understand and make sense of their illness, in meeting patients' wants, and in business efficiency are five dimensions on which one could envisage rating practices and practitioners.

Such a profile would perhaps have two main branches, the hedonic and the hermeneutic. The hedonic would include those models which see success primarily in terms of alteration of objective states, such as reactive and anticipatory care, whilst measures of success would have to be developed for the hermeneutic activities of general practice. Dimensions of paternalism and consumerism, clinical and business efficiency would also need to be included. Measures are possible at different levels of sophistication and with different degrees of ease in different areas. One of the difficulties we face presently is the tendency to place more emphasis on what can easily be measured. We need to identify ways to measure important things which we do not measure at present.

The practical difficulties are formidable, but at least such a multidimensional concept would avoid illogical philosophical assumptions, or imposing fashionable moral values without any justification. Unless or until we can produce a unified philosophy on a sound basis for general practice, this is an intellectually respectable interim measure on which practical work can begin immediately.

The way forward

Since our view of good general practice depends on our philosophical position, as well as our scientific judgement of how best to achieve the ends we desire, there is a limit to the extent to which our difficulties can be resolved by more and better research and more sophisticated clinical skills, necessary though these may be. *What we need is not better research data but better philosophy.* We need to consider the philosophical differences between the models and reconcile them in order to produce a more coherent view of good general practice.

The aim of the present work has been to analyse the situation, not to attempt a synthesis, which is a major work in philosophy to which the above has merely been preliminary groundwork. The reader who is hoping that a solution to the problems raised will be produced in the concluding pages, as in a detective novel, is doomed to disappointment.

The relationship between the models is so far unclear. The impression may have been gained that the models are alternatives and that one must accept one and reject the others. Despite the warning in Chapter 3 readers may have found themselves trying to decide which model they identify with. This is probably not the way to view them. Rather than one being true and the others false, they are unreconciled aspects of a greater truth, just as in physics wave and particle theories of light are both necessary to explain different phenomena although they seem incompatible. If this is the case, however, we have to clarify the relationship between the models.

Even when, as with Balint (1957) and Tudor Hart (1988), new concepts are overtly defined in response to deficiencies of older models, the writers give us no clear guidance as to how they see the new relating to the old. This is perhaps because each of them saw themselves as fine-tuning the old model, or making an unproblematic addition to it. Certainly neither seeks to jettison the older model entirely. The shifts in values which the change implied have not been noticed, or if noticed have not been comprehended. Balint looked at first as if he might provide a clear line of demarcation. In the first book the approach was confined to selected patients who were offered a long interview recognizably different from ordinary general practice. This is described in chapters entitled "How to start" and "When to stop". Although *how* to start was discussed, it was less clear *when* to start. Soon, however, it became apparent that the issues they were concerned with applied not to a select few but to a greater or lesser degree to every consultation. The long interview was then neither practical nor appropriate, and the focus shifted onto ways in which this new insight could become part of ordinary general practice consultations (Balint and Norell, 1973).

The relation between the teleological models and anticipatory care has not been fully explored. Tudor Hart's attitude (1988, p.89) to Balint is to damn with faint praise. To the rationalist anticipatory care doctor the softness of the Balint movement, with its emphasis on feelings, its idiographic focus, and its rejection of the positivist exaltation of the measurable and falsifiable, is anathema. Anticipatory care is in some ways even more rationalist than traditional biomedicine, with an increased emphasis on taking scientific endpoints seriously, audit and evaluation which out-Oslers Osler. Many leading Balintians see anticipatory care even more than the traditional medical model as getting in the way of the patient's real concerns. If the doctor brings a large agenda of anticipatory care aspirations to the consultation, how can she adopt the open patient-centred approach necessary to 'be there', centred on the patient's unconscious concerns?

The rest of this chapter will seek to show how the models might be reconciled by drawing together what we have learnt from the above analysis of different views of general practice. Although this will not provide a solution to the conflicts and inconsistencies it will perhaps provide an agenda for the development of such a solution.

On reconciling conflicting models

The first question is whether a synthesis is possible even in principle. This depends on the fundamental nature of knowledge and conceptual systems, most importantly whether we accept relativism or not, an issue briefly discussed in Chapter 2 in relation to ethics. If we believe that ethical views are entirely subjective and that there is no reason to choose one framework rather than another for our ethical decision making, then the resolution of the conflicts is impossible. Although epistemological relativism is less widely held than ethical relativism, precisely the same argument applies. If the choice between, for example, a dualist and a non-dualist theory of mind is as much a matter of personal preference as a taste for claret or burgundy, then there is little more to say.

The relation between different models making fundamentally different assumptions has been considered at some length in philosophy. We have seen that models of medical practice combine features of an empirical scientific theory of

how we should achieve a given end, and value judgements about what those ends should be. There is philosophical work on the relationship between different scientific theories, and there are also meta-ethical theories of the relationship between different moral systems. Considering our problem in the light of one theorist of each type — MacIntyre and Kuhn — may help us to be clearer about the task we face.

MacIntyre (1985), studying the variety of moral systems which coexist in our society today, reached the conclusion that moral views have to arise from a common set of cultural assumptions, which he refers to as a tradition. Our present state of moral confusion he attributes to the fact that we live in a world in which moral discussion does not take part in a common tradition, which he pessimistically concludes was irretrievably fragmented at the Enlightenment.

He suggests that in a morally pluralistic world there is no alternative to overtly accepting that attitudes differ (MacIntyre, 1977). Since there is no coherent model for good general practice, both doctor and patient must take what they fancy from the moral buffet and try their best to make a satisfactory meal. One doctor may offer one type of service, another a different one. The patient can then choose what sort of practice best suits his or her requirements.

There is a suggestion in the Balint (1957) notion of the apostolic function that this already occurs to some extent, in a covert way. Doctors and patients come to a working relationship by the doctor making it clear by his behaviour what sort of terms he or she is offering; what illnesses or problems are of interest or acceptable, and what are not; and similarly what solutions are on offer. Patients respond either by coming to agree with the doctor's view or by taking their problems elsewhere (or leaving them unresolved). The requirement to give more information to patients about the practice in the form of leaflets was a crude attempt to make this process more deliberate. Since, however, it focused on peripheral details such as doctors' ages and qualifications rather than on their concept of illness and moral values, it is unlikely to lead to much change.

MacIntyre would like to make the process more open. In his view doctors should have lists of moral values posted outside their surgeries in the same way as they have lists of consulting times, and where appropriate scales of fees, so that patients can make their choice.

If we favour this pessimistic view, then at least the work in this paper provides a starting point for making some decisions about what should be on that list: not just attitudes to 'moral problems' such as abortion and euthanasia, but also beliefs on the central issues of medicine such as the nature of illness and the purpose of suffering.

The difficulty with this, which MacIntyre acknowledges, is that this requires both doctors and patients to achieve if not the level of sophistication in moral argument that he does, a level far greater than is the general rule at present. It suffers from the common problem of philosophers' solutions that it requires that we all function as philosophy dons.

Not all moral philosophers hold such a pessimistic view as MacIntyre. Midgeley (1991) argues persuasively that there is a basis for moral consensus in our common humanity. Doyal and Gogh (1991) develop a universal theory of human need on a similar basis, whilst Nussbaum and Sen (1993) provide a convincing basis for an objective catalogue of the virtues as the qualities needed to face the problems that all flesh is heir to.

Even within MacIntyre's analysis there are suggestions that a more optimistic view is possible. One of the conditions which he postulates as necessary for a coherent moral discourse is a "practice", which he defines as:

> Any coherent and complex form of socially established co-operative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to and partially definitive of that form of activity, with the result that human powers to achieve excellence and human conceptions of the ends and goods involved are systematically extended.

It is interesting that, despite his earlier pessimism on being able to achieve a consensus on what the moral values of medicine should be, medicine is one example he quotes to illustrate what he means by a practice.

Perhaps the fragmentation of our moral universe is not as total as MacIntyre believes. It may be that within the co-operative human activity that is general medical practice there is a sufficiently strong tradition which, because of superficial and external moral fragmentation, finds it hard to articulate standards of excellence but nevertheless has deep within it an intuitive concept of what the goods internal to the practice are. If this is so then our task is more akin to archaeology than to architecture, uncovering what is already there and filling in the gaps, rather than building bridges from new material.

A different view on the relationship between incommensurable models which permits us to be more hopeful of developing a consensus is Kuhn's (1962) analysis of the way in which the goods of scientific understanding are systematically extended. He proposes a theory of scientific progress which attempts to explain how one theoretical structure (which he refers to as a paradigm) replaces another.

A pre-requisite for a new scientific theory is that it deals with all those matters dealt with satisfactorily by the old theory, as well as incorporating satisfactorily the problems with which the old theory could not cope, so that overall its explanatory power is greater. Einstein and Infeld (1938) saw things in this light when they wrote that "creating a new theory is not like destroying an old barn and erecting a skyscraper. It is rather like climbing a mountain, gaining new and wider views".

Kuhn has pointed out that there are not merely intellectual but also social factors which influence the change in a major area of theory which he calls a paradigm shift. This requires not merely a few loose ends which the theory cannot deal with, which exist all the time and are mostly ignored by scientists, but a "critical mass" of problems which can no longer be ignored. Even then no shift in paradigm occurs until there is a satisfactory alternative, waiting in the wings as it were to replace the worn out one. No one abandons a paradigm for a vacuum, any more than we throw out old shoes before we have bought new ones. Physicists continued to use the incompatible wave and particle theories in parallel in the absence of any satisfactory synthesis. Even when there is a new paradigm which is adequate there is a certain conservatism, a reluctance to be convinced that it is really necessary and better. We often prefer old, scruffy comfortable shoes to stiff, new smart ones.

Although Kuhn was talking of scientific paradigms and not the applied clinical models with their moral element

which we have been considering, some of the same principles may apply. A new model would need to deal with the main difficulties which the old ones fail to cope with, and include within it the satisfactory elements of previous models. Even then in Kuhn's view it would only be accepted if there were sufficient difficulties with existing models. Whether the present state of flux and radical suggestions for change indicate sufficient problems with our paradigms to make such change possible, only time will tell.

Philosophical differences between the models

It may be possible to use the insights gained in the analysis we have made to move a few metres further up Einstein's mountain, far enough to see a few of the contradictions, gaps and boundaries more clearly. This may also help us to see where our specific problem fits in with respect to the wider problems of medical ethics in particular and of moral philosophy in general.

Resolution of the inconsistencies between the various models which have been defined will require attention particularly to their points of conflict. They will, as it were, define the 'agenda' to be tackled in order to develop a concept of good general practice with secure philosophical foundations.

The principal issues on this agenda will be the nature of the human person, the nature of illness, and its place within a wider view of the purpose of life. From these must follow a dynamic concept of autonomy, a coherent account of the doctor-patient relationship and an adequate theory of justice.

The nature of the human person

A major theme in the analysis in previous chapters has been the view that is taken of the human person. Since human beings are the concern of medicine this is perhaps hardly surprising. We have seen that much of our achievement and much of our thinking is based on a dualist view which sees the human body as a machine to which the analytic techniques of science and engineering can be applied. This brings us considerable benefits both in therapy and prevention which we would be unwilling to abandon, but it also has its limitations. It fails to provide a framework for the pyschological and interpersonal problems which bring people to their doctors, and it does not provide the doctor with any framework for analysing his or her own feelings and actions.

We shall require a concept of human personhood sufficiently sophisticated to comprehend the benefits related to the mechanistic model without confining us by a limited mechanistic view when this is not helpful and a more holistic approach is required. It has to be a model which can account for and justify the role of both doctor and patient in the consultation.

The models have different attitudes to the relationship between the doctor's duties to individual patients, to society and to families. Those heavily based on rationalist individualism — biomechanical and consumerist — naturally lead us to give primacy to the individual. Teleological models such as Balint, with a view of personhood which takes account of the relationships between individuals, are inclined to give more weight to other people who stand in relationships with the patient but still retain a primarily individual focus. Anticipatory care, on the other hand, implies a commitment to the health of the community as a whole.

We need to clarify our ideas on individual personhood and how it fits with the family and the wider society. We saw in the last chapter how ill-defined our concepts of the family and the moral basis of the relationships within families are. This is at least one starting point for our clarification work.

The nature and place of illness and the purpose of life

We have seen that whilst biomechanical and anticipatory care models see illness as something entirely negative, to be separated from and removed from life, teleological/hermeneutic models are more inclined to see it at least on some occasions as part of life to be understood and integrated within it.

Whilst there is a fundamental theoretical difference between hedonist and teleological viewpoints, between trying to abolish death and suffering and trying to come to terms with their inevitability, few would follow either view to the bitter end. Death, like taxes, is ultimately unavoidable, and suffering can only partly be alleviated. Few would deny that doctors have some role in helping patients deal with these unpleasant and unavoidable facts. There is an ancient aphorism defining the doctor's role as "to cure seldom, to alleviate often and to comfort always". Perhaps it makes more sense in this context to think of comfort in its Elizabethan sense of strengthening (as the *Book of Common Prayer* (1662) refers to "The Holy Ghost, the Comforter") rather than the effete, modern sense suggesting babies' dummies, woolly jumpers and padded sofas. We need a model of illness and the purpose of life which recognizes and values this work.

Equally, however, it would be a strangely fatalist doctor who counselled someone with a dislocated finger to help them endure the suffering and deal with the disability, rather than taking swift and simple action to restore the joint to its normal state. 'Greyer' conditions such as depression or irritable bowel syndrome are like Rubin's vase (Vernon, 1962; Hetherington et al., 1964), which can equally be seen in two ways which makes the same pattern look very different.

We need a theory of illness which recognizes both these attitudes and helps us to decide when one is appropriate and when the other should be adopted. This will ultimately relate to an understanding of the purpose of life, our fundamental values. The term 'moral values' has become almost synonymous with a conventional Victorian attitude to sex. It is, however, moral values in the true sense — our understanding of the nature of the good and the purpose of life — which above all things determine our view of good general practice.

This will of course require the adequate concept of personhood discussed above, as well as some hard epistemological and metaphysical thinking.

The doctor-patient relationship

The proper scope of general practice differs between the models. For the Balintian, the consumerist and the biomechanical doctor it is defined by what patients bring, although their views on what the doctor should do with this differs according to their views of the purpose of medicine.

Anticipatory care broadens the scope bringing in illnesses the patient has not complained of or does not yet have.

As well as a defensible view of the end of life, we require to decide the proper place of general practice in achieving that end. If we make a positive decision of agnosticism on the overall end of life, leaving that to the patient, we still need to set limits to the proper concern of medicine. The boundary between the hedonic and hermeneutic aspects of practice will have to be defined. We need to define a soundly rooted and overt view of the proper scope of general practice *vis à vis* both other branches of medicine and other social activities.

Also important to a coherent view of the doctor-patient relationship is an adequate account of personal autonomy. We saw in our discussion of Balint that if we accept that a rationalist, Enlightenment view of the world is too limited, we have problems with the static view of autonomy which is rooted in that model and which has pervaded ethical thinking since that period. We need a more dynamic view of autonomy, which can allow for non-rational interpersonal relationships, without necessarily accepting the paternalistic doctor, if we are to integrate views of life which have a teleological or narrative perspective on life into our view of good general practice.

A theory of justice

None of the models provides a framework in which we can properly tackle the tricky triangular relationship between the doctor, the patient and the State. Tudor Hart begins to look as if he might do so, but most of his solution to this is part of his political philosophy rather than of the anticipatory care model. This is largely because none of the models has a satisfactory theory of justice. It is clear that lack of agreement about what decision would be the most just is an important reason for the difficulty of the cases discussed in Chapter 1. It is also why we found it difficult to reconcile the business and the altruistic elements of general practice in Chapter 7. We also have no theory of justice for the allocation of time and resources between the doctor and her patients.

This is not to suggest that there is a specific theory of justice for general practice; but without a workable one many of the decisions which we need to make become arbitrary or impossible. We need a theory of justice which makes clear what is required for the doctor to act fairly to her patients, her staff and herself.

Apart from that part of jurisprudence which considers just punishments for crime and their basis, and just restitution to hurt in civil law, discussions of justice most commonly concern distributive justice — the allocation of scarce resources between different individuals. There are various principles on which such allocations can be made: according to need, according to merit, according to desert, and so on (Lucas, 1980).

In each case the distribution is often discussed from the point of view of one who sits outside, with no personal stake in the outcome. We are back in the Oxford common-room discussing these matters with scholarly detachment. The courtroom image of the (one hopes) wise and impartial judge sitting apart from and above those affected by the decision often seems to be in the back of the writer's mind, with her in the role of the judge.

Whilst the general practitioner does have to act in this way, particularly in the gatekeeper role (Toon, 1994), the situation we are discussing here is different. The doctor is not only a judge but also a beneficiary in the distribution of resources. The problem is not how to be just between different third parties, but how to be just between oneself and other people. Good general practice is amongst other things centrally general practice which is just.

There is, however, in moral philosophy a basis for an account of justice which includes this aspect. Indeed if it has been neglected in recent discussions in medical ethics, it is central to Aristotle's discussion in the *Nichomanchean Ethics* (Book V). It is interesting that there Aristotle considers that in one sense justice is equivalent to the whole of virtue, a concept which Urmson (1988) argues is better translated as righteousness than justice. Aquinas in the *Summa Theologiae* held that good men are so called chiefly from their Justice (Question 58, article 4). Like the work of MacIntyre, discussed above, these views indicate that perhaps we need not merely an isolated theory of justice but a comprehensive virtue ethic as part of the moral foundation of general practice.

There are other relevant issues which have not been considered here, such as our theory of knowledge and our philosophy of mind. The view of good general practice held by the logical positivist, who believes that only empirically verifiable correlations are knowable, will be very different from that of the idealist, who believes that ultimately what we see with our eyes is not real. Similarly the dualist who believes that there are two parallel worlds of mind and matter will act differently as doctor or patient from the epiphenomenalist or the monist who believes the mind and brain to be inseparably related.

Whether or not it will be possible to resolve all the tensions between different models of general practice is questionable. As MacIntyre (1985) points out, there is a sense in which life is essentially tragic: whatever we do, we cannot avoid leaving undone something else which we ought to have done. What an attempt to resolve some of the underlying differences and inadequacies of the models might do is to help us decide where these choices are real and inevitable, and where they are only apparent. This will be a lengthy and complex work. This paper marks only the beginning of the search for an adequate definition of good general practice.

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